

**A PHENOMENOLOGICAL STUDY OF HEALING IN A NORTH
SOTHO COMMUNITY**

by

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Dedicated to Edzisani and Malapele

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ABSTRACT

The two specific aims of the present study were to: (a). conduct an inquiry into the process of indigenous healing as conceptualized by a group of North Sotho indigenous healers, and (b). to interpret these subjective representations of a healing process so as to develop ideas regarding the links between indigenous healing and modern medicine in forging a new mental health policy for South Africa. Four North Sotho indigenous healers, located in Naphuno district (a predominantly rural settlement comprised of an indigenous North Sotho speaking African population) in the Northern Province, were selected on the basis of the known sponsor approach for the purpose of this study. The interviews with the indigenous healers were audio-taped, and later transcribed and translated. A phenomenological method of analysis as used in the present study involved a number of rigorous stages whereby the original data was reduced and interrogated to identify some emerging meaning units. These naturally occurring meaning units were further interrogated to identify emerging themes which were ultimately synthesised into consistent psychological thematic structures.

Three themes, each addressing some aspect of the process of indigenous healing, were consequently identified. The themes are:

- # "Go thwasa" (becoming an indigenous healer) is a preparatory step that leads to integration of personality, acquisition of clinical competencies and attainment of some transcendental experiences.*
- # Indigenous healers attach culturally congruent labels to clusters of physical and psychological symptoms presented by their clients.*
- # Indigenous healing is a multi-phasic process that is aimed at the client and the total home environment while at the same time providing an opportunity for some to access spiritual dimensions of their experiences.*

Given the above three themes, it is argued that indigenous healing is a logical and culturally patterned therapeutic system that needs to be developed and legitimized as a health care resource in South Africa. In view of its potential usefulness as a national health asset, it is proposed that indigenous healing in South Africa be allowed to operate as a parallel self regulating health service. In this respect, indigenous healers might consider setting up a national

body that would regulate, control, and determine training and ethical standards for indigenous healers. Furthermore, such a national body would liaise with the government for the purpose of encouraging provincial health departments and district health units to work closely with indigenous healers so as to provide a holistic health service to the local community. It is at such local levels that specific forms of collaboration between indigenous healers and modern health practitioners would be worked out in order to accommodate the unique interests, local cosmologies and cultural peculiarities of indigenous healers and communities in each province.

GLOSSARY

<u>Ngaka</u>	<i>This is a general term for traditional / indigenous healer (plural - <u>dingaka</u>). Some of the equivalent words in other indigenous South African languages are: <u>igqira</u> (Xhosa), <u>inyanga</u> (Zulu), and <u>nanga</u> (Tshivhenda). Other concepts like: <u>isangoma</u> and <u>abalozi</u> (Zulu), and <u>sedupe</u> (North Sotho) refer to specialist categories of indigenous healers. Some traditional healers known as <u>dingaka tsa malopo</u> in the North Sotho community are believed to go into a trance-like state known as <u>malopo</u>. During this altered state of consciousness, such an indigenous healer is believed to be in contact with the ancestors. A trance-like state known as <u>intlombe</u>, and almost similar to <u>malopo</u> is also observed among the Xhosa people.</i>
<u>Kgoshi</u>	<i>Terms like traditional leader and chief have been used in South Africa to refer to this category of people who become leaders of communities by virtue of being born into a royal family. There is currently a move orchestrated by the National House of Traditional Leaders to discard the use of these terms in favour of indigenous concepts like <u>kgoshi</u> (North Sotho), <u>khosi</u> (Tshivhenda), <u>hosi</u> (Xitsonga), <u>inkosi</u> (Xhosa).</i>
<u>Go thwasa</u>	<i>The process through which an individual becomes an indigenous healer. This process is usually preceded by some pre-training experiences which are in the form of an illness or unpleasant dreams.</i>
<u>Badimo</u>	<i>Ancestors. These spiritual entities are believed to be omnipresent and to guide a <u>ngaka</u> in his practice.</i>
<u>Molwetsi</u>	<i>A patient - someone who is ill and in need of treatment (plural = "balwetsi").</i>
<u>Ntlo ya badimo</u>	<i>House of ancestors (literal translation). Indigenous healers use this concept to refer to their consulting rooms.</i>
<u>Ditaola</u>	<i>Divination bones.</i>
<u>Phuthulla moraba</u>	<i>To open a bag (literal translation). An initial fee that a patient is expected to pay during the first consultation.</i>

<u>Go laola</u>	<i>To divine or to assess. Through this activity the indigenous healer would be in a position to establish the nature of a problem and to propose an appropriate intervention strategy. A number of assessment methods ("mekgwa ya go laola") are used by different indigenous healers to establish the nature of the problem.</i>
<u>Kalafo</u>	<i>Treatment (treatment methods = "mekgwa ya kalafo").</i>
<u>Vumisa</u>	<i>A diagnostic / divination session. During such a session, an indigenous healer will establish the nature of a problem and prescribe an intervention programme.</i>
<u>Go huetsa</u>	<i>To breathe into something. Before the divination bones can be thrown on the floor, an indigenous healer will advise a consultee to <u>huetsa</u> (breathe into) the bones.</i>
<u>Leswiswi</u>	<i>Darkness.</i>
<u>Moya</u>	<i>Spirit or air. In the context of this thesis <u>moya</u> refers to spirit as in holy spirit.</i>
<u>Letlalo la ditshila</u>	<i>Dirty skin.</i>
<u>Senyama</u>	<i>Bad luck. Also known as <u>sefifi</u>. An equivalent of this condition in the Nguni culture would be <u>umego</u> (a Zulu word literally meaning the act of stepping over a harmful substance).</i>
<u>Sefolane</u>	<i>Deadly physical illness that is characterized by swelling of limbs.</i>
<u>Phambana</u>	<i>A psychotic-like condition which is characterized by a number of clinical features like idleness, extreme aggression, social isolation, disregard for customs, and running around aimlessly.</i>
<u>Mafofonyane</u>	<i>(<u>Amafufunyana</u> in Xhosa) - It is a mental illness that is characterized by psychotic features like voice hearing and poor contact with reality. This disorder is believed to be caused by witchcraft.</i>
<u>Botwetsi bja go wa</u>	<i>Epilepsy.</i>
<u>Tokoloshe</u>	<i>In most African communities, it is believed that a witch can make use of familiar spirits to harm others. <u>Tokoloshe</u> is one such a familiar spirit that usually takes an animal form.</i>
<u>Diso</u>	<i>Rash.</i>

<u>Metsho</u>	<i>A childhood illness characterized by strange experiences like excessive crying, restlessness, and hallucinations. A number of other childhood illnesses have been identified. These include: <u>lekone</u>, <u>mootlwa</u> and <u>bolwetsi bja ditshwene</u>.</i>
<u>Leeta</u>	<i>A piece of broken clay pot. It is usually used for the administration of herbs.</i>
<u>Go orela</u>	<i>To inhale smoke from burning ashes.</i>
<u>Tshidi</u>	<i>Ground ash that is used by traditional healers as medicine. There are various types of <u>tshidi</u> and these include <u>maloimaleko</u> and <u>tshidi ya badimo</u>.</i>
<u>Go hlabela</u>	<i>To make incisions that are deep enough to cause bleeding. This minor operation is followed by the application of some herbs to the incisions.</i>
<u>Segokgo</u>	<i>Something bound together (literal translation). <u>Segokgo</u> is prepared by combining some barks, roots, twigs, and leaves of some trees or shrubs so as to make a small bundle which is boiled to produce some juice that is administered as medicine.</i>
<u>Letlobo</u>	<i>The skin that has been shed by a snake.</i>
<u>Go swaba</u>	<i>To be shy.</i>
<u>Go hlapisa</u>	<i>To bathe somebody (literal meaning). In the context of this thesis <u>go hlapisa</u> is to apply medicines in the form of a bath. Such medicines are believed to have a purifying effect on the patient.</i>
<u>Go thekga</u>	<i>At times, indigenous healers make use of certain intervention strategies that are believed to help protect an individual, his family, and homestead against current and potential illnesses and misfortunes. When the intention is to protect an individual this will be referred to as <u>go thekga motho</u>. On the other hand, if the intention is to protect a homestead this will be referred to as <u>go thekga motse</u>. Also referred to as <u>go aga motse</u>.</i>
<u>Intelezi</u>	<i>Buffalo thorn. Among the Zulu people, this tree is planted in a homestead to serve as a protective measure against witchcraft and lightning.</i>

Xentsha

One of the rituals performed by Xhosa people at different life stages. Such rituals are for the purpose of restoring good health and maintaining contact with ancestors.

Isiko lentambo

Another Xhosa ritual that is performed for the purpose of restoring good health and maintaining good contact with the ancestors.

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CHAPTER 1

INTRODUCTION

One of the major areas of interest in the field of mental health is the relationship between culture and the notions of illness and psychotherapy. This area first emerged as a popular topic of inquiry with the publication of several books during the 1960s including Frank's (1961) *Persuasion and Healing*; Kiev's (1964) *Magic, Faith and Healing*, Murphy and Leighton's (1965) *Approaches to cross-cultural psychiatry*, and Prince's (1968) *Trance and Possession States*. The common thread in all these books is that they call attention to the role of cultural factors in various psychological interventions around the world. During the same period, several journal articles were published detailing the procedures involved in various healing practices across cultures (Baasher, 1967; Kora, 1965; Lambo, 1960; 1961; Kennedy, 1967; Maupin, 1962; Murphy, Wittkower & Chance, 1964; Wittkower & Rin, 1965). In the 1970s, several publications that provided reviews of the issues and concrete examples of psychotherapy and healing across cultures emerged. These included Kiev's (1972) *Transcultural Psychiatry*, Torrey's (1972) *The Mind Game: Witchdoctors and Psychiatrists*, Lebra's (1976) *Culture Bound Syndromes, Ethnopsychiatry and Alternative Therapies*, Leslie's (1976) *Asian Medical Systems*, and Ademuwagun, Ayoade, Harrison and Warren's (1979) *African Therapeutic Systems*. In recent years, numerous publications have also focused on the role of culture in various healing practices across the globe (see Desjarlis, Eisenberg, Good & Kleinman, 1995; Goldberger, 1995; Kleinman, 1987; 1988; Landrine, 1995; MacLachlan, 1997; Marsella & White, 1982a; Matsumoto, 1996; Meadow, 1982; Pedersen, 1984; Reynolds, 1996; Sue & Zane, 1995; White & Marsella, 1982).

It is against this background that several scholars in many non-Western societies began to challenge the universalist notions of illness and healing as represented in most European and North American psychological literature (Beit-Hallahmi, 1974; Connor, 1982; Kim & Berry, 1993; Lebra, 1982; Meryar, 1984; Murase, 1982; Sinha, 1973; Turtle, 1989; Wu, 1982). Similar developments are also evident in Africa (Akim-Ogundeji, 1991; Awa, 1986; Durojaiye, 1982; Ezeilo, 1992; Howitt & Owusu-Bempah, 1994; Makinde, 1988; Nsamenang, 1993; Peltzer, 1995). In South Africa, the interrogation of euro-centric psychological approaches and the search for appropriate and culturally sensitive models of illness and healing is recently achieving

prominence (Bodibe, 1993; Bodibe & Sodi, 1997; Buhrmann, 1984; Gobodo, 1990; Holdstock, 1979; 1981; Manganyi, 1973; 1977; 1981; 1991; Sodi, 1996b;). It is this discourse around the relevance of Western psychological models of illness and healing in (South) Africa that forms the background to the aims of the present study.

1.1. Psychology in Africa: concerns and the relevance debate

1.1.1. The colonial tradition of psychology

The first phase of colonial conquest of Africa by the West was characterized by brutal military conquests, slavery, and economic and social exploitation (Awa, 1986; Bulhan, 1981; 1993; Mazrui, 1986; Mudimbe, 1988). According to July (1968), this initial phase was visibly violent and amoral as the conquerors were only interested in "extracting profit" from trade, first in gold and other goods, and then primarily in slaves.

The second phase of colonialism, which was aided by increased technological development and industrialization, involved a transition to disciplinary power (Fanon, 1967). This relatively subtle form of power and control was characterized by the imposition of mechanized, regulated, and impersonal social systems requiring a high degree of conformity (Comaroff & Comaroff, 1991; Mudimbe, 1994). By its very nature as a human science, psychology became a useful technological system in the quest to subject Africans to individualizing examinations, classification, regulation, and supervision - the activities which were all in the service of the project of disciplinary power (Mudimbe, 1994). According to Bhabha (1990), it was this "gaze of Western percipients" (p.214) that gave rise to the myth of Africa as Other.

With the colonial discourse of Africa as Other, images of Africans as savages, barbarians, and primitive (Bhabha, 1990; Comaroff & Comaroff, 1991) gained ascendancy. According to Pieterse (1992), it is these images that were de-spatialized, psychologically interiorized, and redefined by Freud as instincts which are supposed to dwell in the unconscious. Pieterse's view is shared by Manganyi (1985) who accused Freud of having contributed to a modern denigration of African communal values by portraying "primitive man" as part of a permanent mob and thus having no sense of individuality. The criticism of early psychological thought and its role as a

handmaid in the colonial scheme, has continued to the present day as modern psychological discourse stands accused of perpetuating the myth of Africa as Other (Bulhan, 1990; 1993; Hickson & Kriegler, 1991; Nicholas, 1990).

Several proposals that are aimed at ridding psychology in Africa of its colonial legacy have been made. For example, it has been suggested that psychology should be overtly political in aim (Akbar, 1984; Cooper, Nicholas, Seedat & Statman, 1990; Seedat, 1990) by aligning itself with the oppressed (Anonymous, 1986; Bulhan, 1985; 1990; Dawes, 1985; 1986), so that it can become an instrument of liberation (Beit-Hallahmi, 1974; Bulhan, 1993; Seedat, Cloete & Sochet, 1988). Freeman (1991) proposes that psychology should address itself to the mental health of Black people whilst Nsamenang (1993) and Sinha (1984) are of the view that this discipline should become a useful instrument for the restructuring and development of society.

1.1.2. Knowledge, power, and psychology

Like many other Western knowledge systems, psychology was brought to Africa during the period of Western political domination (Bulhan, 1981; Sinha, 1984). Wittingly or unwittingly, the discipline of psychology collaborated in the establishment of colonial power relations that not only resulted in the sociopolitical and economic domination of Africa (Awa, 1986; Bulhan, 1981), but also in the suppression of indigenous knowledge systems (Bhabha, 1990; Bulhan, 1981; Fanon, 1973; Manganyi, 1985; Simone, 1993).

In his incisive analysis of the history of Western systems of thought, Foucault (1967; 1970; 1973; 1977, 1980a; 1980b) asserted that the emergence of modern forms of power was dependent upon progress in the construction of certain scientific knowledges that aspire to a "truth" status. These knowledges, which necessarily become the domains of power, will assume ascendancy over others and thus become "technologies of power" (Foucault, 1980b). Through these "technologies of power", Foucault continued, alternative knowledges are relegated to a status of disqualified knowledges. Such disqualified knowledges would include local and popular representations of reality. Following this analysis of Western systems of thought, it becomes clear that the ascendancy of psychology as a human science has disqualified other knowledge systems that sought to explain the human condition.

Based on the Foucauldian notion of knowledge and power, psychology in Africa can be accused of having silenced the African voice as a result of its aspiration to be a theoretical, unitary, and formal scientific discourse. In contrast, Foucault - and it is worth noting that he was a psychologist (Parker, 1995) - calls for the grounding of any prevailing knowledge system within a historical critique whilst also empowering disqualified knowledges in order to be "capable of opposition and of struggle against the coercion of a theoretical, unitary, formal, and scientific discourse (Foucault, 1980b, p.85).

1.1.3. The illusion of ideological and scientific neutrality

As a result of its positivist tradition, psychology has tended to portray itself as a science whose objective researchers and practitioners not only uncover the truth about human behaviour (Bulhan, 1981), but also help individuals to adjust to the demands of everyday life (Prilleltensky & Fox, 1997). According to Gergen (1992), it is a result of this epistemological foundation that psychology developed the following overarching assumptions: (i). that it has a basic, knowable subject matter; (ii). that this subject matter has universal properties; (iii). that this subject matter may be uncovered through the empirical method; (iv). that the results are objective and devoid of ideology and values; and, (v). that research is a progressive enterprise that moves towards truth.

Gergen (1992) referred to the above assumptions as "presumptions" as they tend to ignore that psychology takes place within the narrative conventions of Western culture. Furthermore, Gergen argued, psychologists could not claim to be engaged in an objective and value / ideology free production of knowledge as they and their scientific procedures are saturated by Western cultural values. A similar view has also been expressed by many other critics of the notion of a neutral psychology (see Bulhan, 1993; Dawes, 1985; 1986; Kvale, 1992a; 1992b; Parker, 1989). As Prilleltensky and Fox (1997) put it:

"Psychology is not, and cannot be, a neutral endeavour conducted by scientists and practitioners detached from social and political circumstances. It is a human and social endeavour. Psychologists live in specific social contexts. They are influenced by differing interests and complex power dynamics. Mainstream psychology too often shy away from the resulting moral, social and political implications" (p.3).

What Prilleltensky and Fox, Gergen and many others (see Burman, 1997; Harris, 1997; Kvale, 1992a; 1992b; Moghaddam & Studer, 1997; Parker, 1989; 1995; Reed, 1996; Spears & Parker, 1996) are suggesting is that psychologists need to acknowledge that their own values, biases, and assumptions affect the knowledge they produce. This point has been eloquently illustrated by Dawes (1986) who saw the psychologist's role being:

"... to expose the interests which are served by uncritical psychological theory and practice, and to call for a reconceptualization of the subject matter of psychology which takes account of the social / ideological discourses which structure the individual person, the psychologist as theorist, researcher and practitioner, and the knowledge which they produce" (p. 34)

1.1.4. Psychology's euro-centric heritage

Several writings have accused psychology in Africa of being Euro-centric (Akin-Ogundenji, 1991; Awaritefe, 1977; Bulhan, 1990; Serpell, 1984; 1992) and unresponsive to the needs of the inhabitants of the continent (Abdi, 1985; Erinosh, 1975; Guthrie, 1976; Nsamenang, 1993; White, 1984). Central to these accusations is the view that psychological theories (like psychoanalysis and Piaget's developmental theory) are embedded in a Western socio-political matrix (Cushman, 1995). Other critics have suggested that instead of regarding them as universal, we should rather understand these psychological theories as elements of a minority ethno-psychology of the modern Western subject (Burman, 1997; Ingleby, 1995; Shweder, 1991; Shweder & Bourne, 1982). Dawes and Honwana (1996) addressed this point by challenging the universality of developmental psychology enterprise:

"Conceptions of optimal development, children's needs, and our practices towards children, are therefore, located in cultural moralities. They are not universally agreed upon, and our regime of truth about appropriate development for children, reflects the location of the mental health disciplines in a particular cultural time" (p.40).

Psychology's euro-centrism is pertinently demonstrated in the application of psychotherapeutic approaches which tend to focus mainly on the individual (Awanbor, 1982; 1985; Landrine, 1995; Sue and Zane, 1995). As Gaines (1982) put it:

"Talk and insight therapies are clearly based upon some notion of self as an alterable yet consistent and coherent entity which is self-reflective ... [These therapies] entail an implicit ... conception of the person as an empirical being always in the process of becoming or, for that matter, unbecoming" (p.182).

According to Marsella and White (1982), such therapies would not be appropriate for a person who comes from a socio-centric cultural milieu (like in the case of most African cultures) where psychological problems may be explained in terms of socio-moral conflict or strained relationships within a significant social group. In such a socio-centric culture, Marsella and White continued, effective psychotherapy should entail treating the relationships - the marriage, the family, the relationship between the person and various immaterial beings. Other approaches favoured as relevant to the needs of African communities include the implementation of community psychology (Hickson & Kriegler, 1991; Seedat, Cloete & Sochet, 1988), the mobilization of traditional African healing approaches (Bodibe, 1993; Buhrmann, 1977; 1977; Holdstock, 1979; 1981; Kruger, 1974; Sodi, 1996a; 1996c) and the indigenization or Africanisation of psychology (Akin-Ogundeji, 1991; Asante, 1990; Dawes, 1996; Kottler, 1990).

1.2. Aims of the present study

The two specific aims of the researcher in this study are:

- # to conduct a phenomenological inquiry into the process of indigenous healing as conceptualized by a group of North Sotho indigenous healers.
- # to interpret these subjective representations of a healing process in order to develop ideas regarding the links between indigenous healing and modern medicine in forging a new mental health policy for South Africa.

By addressing the above issues, it is hoped that the study will:

- # identify some essential psychological ingredients that make indigenous healing a popular health care choice for many people in South Africa and the rest of the continent.
- # provide useful data that could inform the current debate in South Africa about possible collaboration between indigenous healers and their Western oriented counterparts;
- # contribute to the understanding of African epistemologies in developing and applying psychological knowledge in Africa and other non-Western countries.

- # make a contribution to the relevance debate which has developed out of the recognition of the inappropriateness and inaccessibility of psychological theories to the majority in Africa.

1.3. Organization of the thesis

This thesis consists of nine chapters. The purpose of the present chapter was to identify central concerns that have been raised about the place and role of psychology in (South) Africa, and to introduce the resulting relevance debate that has provided a motivation for conducting the present study. Having provided the context, I moved on to state the specific aims of the investigation and also to point out some of the possible contributions that this study could make to psychology in particular and to mental health in general.

In Chapter 2 I will give a review of some of the international literature that has sought to demonstrate how the experience of illness, together with the various healing procedures are culturally patterned. In the first section of the chapter I will look at the various representations of the self and how these culturally determined assumptions underlie clinical reality. The second section of the chapter will focus on the notion of illness and how culture influences its conceptualization and the therapeutic strategies that will be found appropriate. In the third section I will give a discussion on shamanism in order to illustrate some of the pertinent issues that are raised in the other two sections of the chapter.

The purpose of Chapter 3 is to review the literature pertaining to culture, illness and healing within an African context. To this end the chapter will be divided into three sections. In the first section I will give a review of the literature that gives an epidemiological picture of mental illness in Africa. The problems associated with such an endeavour will also be identified and articulated. In the second section, I will look at the cultural meanings of mental illness in Africa as well as some of the strategies that people in this continent may employ to restore good health. In this regard, indigenous explanatory models of mental illness of specific countries like Mali and Zimbabwe will be sampled and discussed. In the third section I will review some of the psychological studies that have attempted to explain certain African experiences of illness and healing.

Chapter 4 will address itself to two important aspects about indigenous healing in South Africa. In the first section of the chapter, I will give a review of the literature on culture, illness and healing in the South African context. In this regard I will touch on a number of topics like indigenous explanatory models of illness and some of the diagnostic and therapeutic methods that indigenous healers use. In the second section of the chapter several Western psychological theories that have been advanced to explain indigenous healing are presented. Some of the strengths and weaknesses of these psychological studies are identified and discussed.

The method of investigation used in the present study is presented in Chapter 5 which I have divided into two sections. In the first section, I look at the ongoing philosophical debate about quantitative versus qualitative research. A motivation for adopting a qualitative approach and, in particular a phenomenological method, follows from this debate. In the second section of the chapter, the more technical aspects like methods of data collection and analysis are presented.

The results of the investigation are presented in Chapter 6 and 7. The purpose of Chapter 6 is to present the naturally occurring meaning units (NMUs) and the central themes that are derived from these meaning units. For practical reasons, Chapter 7 is divided into two parts. In Part A, all the central themes identified in Chapter 6 are put together to communicate specific or context bound psychological descriptions that emerge from each protocol. In Part B, all the context bound descriptions are synthesized into some general psychological descriptions which are presented as hypotheses which constitute the conceptual framework for explaining indigenous healing.

Chapter 8 addresses the implications of the study for mental health policy in South Africa. In the first section of the chapter I look at some of the international efforts that are aimed encouraging the training and utilization of indigenous healers in the developing countries. The pioneering work of the World health Organization in providing proposals and guidelines in this regard is reviewed. A discussion is also given on how China, Ghana, and Zimbabwe have tried to develop policy around the utilization of indigenous healing as a national health resource. In the second section I will focus on the position of indigenous healing in South Africa. Having

presented the current situation in South Africa, I will move to the third section which is intended to contain some specific proposals about the way forward for South Africa vis-a-vis indigenous healing. The aim of the final chapter, i.e. Chapter 9, is to summarize the results and to point to the limitations that are associated with a study of this nature.

Note on gender terminology

For the purpose of consistency I have preferred to use male gender terminology like "he, "him", and "his". Only in those cases where clear reference is made to a female, was the appropriate terminology used. The intention was not to perpetuate male dominance as generally manifested in psychological discourse.

CHAPTER 2

CULTURE, ILLNESS, AND HEALING: AN INTERNATIONAL PERSPECTIVE

2.1. Introduction

According to Geertz (1973), culture is a socially established pattern of meaning that is responsible for controlling, shaping, and ordering people's emotions, behaviour, and even cognitive activities like thinking which have been construed by behaviourist theories as "happenings in the head" (p.45). Based on this "control mechanism" view of culture, experiences like illness and healing could thus be seen as enterprises that are constructed in social situations and according to the premises of cultural theories prevailing in a particular society. This view has been expressed by many authors whose primary aim was to challenge the universalist notions of mental health by drawing attention to the role of culture in shaping the expressions of and responses to various forms of psychological distress (Fabrega, 1982; Good & Good, 1982; Kleinman & Sung, 1979; Landrine, 1995; Lock, 1982; Matsumoto, 1996; Shweder & Bourne, 1982; Sue & Zane, 1995; Wu, 1982). As White and Marsella (1982) remarked: "Expressions of psychiatric illness in thought and behaviour are of necessity mediated by the symbolic forms of language and culture" (p.3). It is this conceptualization of culture and its role that will form the basis of the debates that will be presented in this thesis.

The purpose of the present chapter is to give a review of some international literature that has sought to demonstrate how the experience of illness together with the various healing procedures are culturally patterned. In the first section I will look at the various representations of the self and how these culturally determined assumptions are beneath the clinical explanations of normalcy and illness in different societies. In the second section of the chapter I will look at the notion of illness and how culture influences its conceptualization and the healing approaches that will be adopted. The third section will focus on shamanism as one of the cultural systems that is mobilized in some societies to explain and to respond to some experiences that are regarded as distressful.

2.2. Culture and the notion of self

Gaines (1982) employs two useful terms, namely referential and indexical in creatively viewing the self across cultures. In his view, the conception of the person implicit in almost all Western psychological theories and psychiatry is that of a referential self - a notion of the self which is deeply rooted in the European and American assumption of the individual as an autonomous, independent, and separate entity that is presumed to be the originator, creator, and controller of behaviour.

Shweder and Bourne (1982) also draw a distinction between two types of self in different cultures. These two authors eloquently make use of the boundary metaphor to illustrate how the "discrete" and "inviolable" self of American society significantly differs from that of Asian and Pacific cultures where the self is taken to have "loose" or "permeable" boundaries. It is for this reason, Shweder and Bourne maintained, that Americans will tend to make greater use of individuated psychological types of explanatory constructs in describing social behaviour. Whilst making a distinction between two conceptions of the self, these two authors warn against a temptation to give a scientific status to these two different notions of the self. As they put it:

"It is crucial to recognize that neither of these conceptualizations of the relationship of the individual to society has the epidemiological status of a scientific category. They are not inductive generalizations. They are not the discoveries of individual perception. Quite the contrary, the egocentric [referential] and socio-centric [indexical] views of man are creations of the collective imagination. They are ideas, premises by which people guide their lives, and only to the extent a people lives by them do they have force" (Shweder & Bourne, 1982, p.131).

Drawing extensively on Gaines' (1982) conceptualization of the referential and indexical self, Landrine (1995) sought to illustrate how these unconscious and culturally determined assumptions constitute a psychological, symbolic universe, or canopy in and through which members of a particular culture exist. In his analysis of the referential self, Landrine identified the following taken-for-granted assumptions that are beneath various Western clinical concepts:

(a).The self is presumed to be an entity; a bounded, unique, singular, encapsulated, non-corporeal, ghostlike, and godly entity somewhere within the body. Any experience of the self as unbounded, multiple, and fragmented will thus be construed, in the West as a symptom or type of psychopathology;

(b).The self is presumed to be a cognitive and emotional universe; the centre of awareness, emotion, judgement and action. "Thus psychopathology is also defined in Western culture as experiencing one's thoughts and feelings as emanating from somewhere other than the self, and as experiencing these as controlled by someone / something other than the self; such beliefs are thought to be thought disorder, delusion, or obsession-compulsion" (Landrine, 1995, p.747).

(c).The referential self is presumed to be a free agent - to be an agent that does what it wishes. Such a self will necessarily have, among others, the right to privacy and autonomy. Any "intrusion" or failure by the individual's family to respect these rights will be construed as a form of family pathology that warrants some therapeutic intervention.

(d). The self is unconsciously assumed to be morally responsible for behaviour which is all constructed to be a mere consequence " ... of the activities, decisions, choices, preferences, whims, and processes of an independent, free self within the body" (Landrine, 1995, pp.748-749). Thus, any attribution of one's behaviour and thoughts to forces or persons other than the self will be regarded as manifestations of some form of psychopathology.

e). The self is expected to act upon the world and others in order to meet its needs. Failure for the referential self to develop itself and to act upon the world will be construed, among others, as helplessness, lack of assertiveness, and submissiveness.

(f). Relationships for the referential self are derivative. What Landrine suggests here is that the self in Western culture is assumed to come first while relationships are a secondary derivative of the interactions of different selves. "We" is thus construed as an association of "I's", where each "I" is taken to be an autonomous and unique entity that has needs and traits of its own. In the process of fulfilling its needs, such "I" may have trouble getting along with other "I's".

The dominant view of the self as presented above has been criticized for being deeply rooted in the Protestant tradition of Western culture (Gaines, 1982) and thus reflecting the representation of person only in such a socio-historical environment (Gergen, 1992; Lykes, 1985; Parker, 1989). To quote Landrine (1995) at this point:

"This referential construction of the self is buttressed by the social and political ideology of individualism that characterizes Western culture, as well as by the psychology and psychiatry of those cultures. The referential self is explained and justified by our [Western] psychological theories of moral and personal development, in which the referential self is said to be the normal outcome of normal development. It is further justified by our concepts of psychopathology in the sense that these psychiatric 'symptoms' and 'disorders' are violations of Western cultural assumptions about how the self ought to be experienced" (p.750).

Extensive theoretical and empirical evidence has been presented to argue convincingly that many peoples in non-Western societies have an indexical construction of the self (Bharati, 1981; Connor, 1982; Crapanzano, 1981; Gaines, 1982; Heelas & Locke, 1981; Landrine, 1995; Lykes, 1985; Nobles, 1976; Rothbaum, Weisz & Snyder, 1982; Shweder and Bourne, 1982; White & Marsella, 1982, 1982). Geertz (1975) for example, asserts that:

"... the Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgement, and action organized into a distinctive whole and set contrastively both against other such wholes and against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures" (p.48).

There is, Geertz (1975) notes, in Bali:

"... a persistent and systematic attempt to stylize all aspects of personal expression to the point where anything idiosyncratic, anything characteristic of the individual merely because he is who he is physically, psychologically or biographically, is muted in favour of his assigned place in the continuing, and, so it is thought, never-changing pageant that is Balinese life. It is ... *dramatis personae*... that in the proper sense really exist. Physically men come and go - mere incidents in a happen-stance history of no genuine importance,

even to themselves. But the masks they wear, the stage they occupy, the parts they play, and most important, the spectacle they mount remain and constitute not the façade but the substance of things, not least the self' (p.50)

Balinese culture's tendency not to separate the individual from the social context is similar in many ways to other socio-centric (as opposed to Western, individualistic, or egocentric) cultures where the indexical self takes the form of social roles (Gaines, 1982; Geertz, 1973; Shweder & Bourne, 1982). According to Sampson (1989), in these socio-centric cultures the self and the roles it occupies are unconsciously presumed to be synonymous:

"Persons are seen as creatures whose very identities are constituted by their social locations. There are no subjects who can be defined apart from the world; persons are constituted in and through their attachments, connections, and relationships ... persons do not choose the ends or purposes they will select to follow, but rather they engage in a shared, common process of discovery in which their goals and purposes are revealed in a never-ending process of living with others ..." (pp. 914 - 915).

Sampson's (1989) assertion was also echoed by Landrine (1995) who went on to identify certain assumptions that are beneath the indexical self of socio-centric cultures. Firstly, Landrine sees the indexical self as having no enduring, trans-situational characteristics, traits, desires or needs of its own in isolation from its relationships and contexts. Secondly, the indexical self is understood to be considerably inclusive in the sense that its boundaries are not drawn around an individual but around a "foyer" that includes family members, deceased relatives, and deities. What Landrine suggests here is that the indexical self includes certain forces over which the individual will have little control.

2.3. Culture and conceptions of mental illness and healing

The history of modern psychiatry and psychology are generally traced back to the writings of Hippocrates (c.460 -c 360 B.C.), a Greek physician of antiquity who is regarded as the father of medicine. Hippocrates argued that all forms of illness (including mental illness) result from some malfunction within the body. For example, in his explanation of epilepsy, Hippocrates made the following remarks:

"If you cut open the head, you will find the brain humid, full of sweat and smelling badly. And in this way you may see that it is not a god which injured the body, but disease" (cited in Zilboorg & Henry, 1941, p.44).

Hippocrates' attribution of various illness types to natural causes, as is the case in the above extract, was a significant departure from the supernatural views that were popular during his time. A number of studies have shown that Hippocrates' contributions to Western psychiatry and psychology were threefold (Holmes, 1994; Sarason & Sarason, 1993).

First, Hippocrates set himself the task of actually observing cases of mental illness and of recording his observations in as objective a manner as possible. Consequently it is in his writings that the first empirical descriptions of such mental disorders as phobia, epilepsy, and postpartum psychosis are encountered (Holmes, 1994). Second, Hippocrates is regarded as the first Western scientist to have attempted a unified classificatory system of mental illness. He classified mental illness into three categories: mania (abnormal excitement), melancholia (abnormal dejection), and phrenitis (brain fever). It is this crude classification of abnormal mental states that influenced Kraepelin in the late nineteenth century to develop the first truly comprehensive classification of mental disorders which subsequently paved the way for World Health Organization's (1994) *International Classification of Diseases* (now in its tenth version) and the American Psychiatric Association's (1994) *Diagnostic and Statistical Manual* which is now in its fourth version. Third, Hippocrates developed one of the first biogenic theories of abnormal behaviour. Though he recognized the role of external stress in psychological distress, Hippocrates attributed mental disturbance to internal processes. For example, he believed that various personality disorders were due to an imbalance among four humours, or vital fluids, in the body: phlegm, blood, black bile, and yellow bile. For example, an excess of phlegm was believed to render people indifferent and sluggish whilst excessive blood was seen as the cause of rapid shifts in mood.

With the ascendancy of the medical approach that developed as a result of Hippocrates' pioneering work, biology became the bedrock (the source of pathogenesis) of all forms of mental disease (Kleinman, 1988). Consequently, all social and cultural layers of reality were held to be epi-phenomenal (i.e., they were seen to exert merely patho-plastic effects). Kleinman (1988)

portrayed this pathogenetic/patho-plastic model by making reference to paranoid delusions in schizophrenia. In this clinical case, the biologically based disease is said to cause the structure of delusional thought processes whilst the system of cultural beliefs is said to organize the content of paranoid thinking. For example, whilst an American with a delusional system may have irrational fear of the CIA or communists, a paranoid person in a non-Western culture may hold a false belief about persecutory ancestral spirits who need to be atoned.

A number of studies have pointed out that psychiatry and psychology of modernity (whose subject matters include nosological categories like paranoia, anorexia and depression discussed above), are knowledge systems that are premised on the referential notions of the self - a conceptual framework that is deeply embedded in an European socio-cultural matrix (Bharati, 1981; Clement, 1982; Gergen, 1992; Landrine, 1995; Lykes, 1985; Marsella, 1982; Nobles, 1976; Sampson, 1985; Sue and Zane, 1995; White, 1982, Wu, 1982). As Shweder and Bourne (1982) have pointed out, these conceptions are however minority views among the cultures of the world. To this White and Marsella (1982) added:

"[Even] ... the very notion of 'mental illness' as a domain of behavioral and medical experience is a product of specific cultural and historical traditions which regard certain forms of behavioral dysfunction as essentially psychological and medical in nature ... [Even] the component words of the phrase 'mental illness' reflect underlying assumptions which generally locate the causes of disorder in individual minds, personalities and neuroanatomies, and which view appropriate treatments as analogous to the treatment of medical disorders generally. As incorrigible as these basic suppositions seem in the context of modern medicine and psychiatry, they are predicated on assumptions about the nature of persons and social behaviour which are symbolic constructions and which contrast with symbolic constructions of other cultures" (p.5).

To amplify the above sentiment I have chosen to present two non-Western models of mental illness and healing which are meaningful if understood from within their socio-cultural context. The first cultural model that I will present is Samoan indigenous knowledge of mental disorders and some of the cultural healing responses that are invoked by these conditions of ill health. A study by Clement (1982) found that the Samoan people generally divide mental illness

into three categories, namely, severe and apparently incurable mental abnormalities ("ma'i valea"), conditions due to spirit possession ("ma'i aitu"), and conditions that are caused by experiencing an excess of emotion. In the case of the first category, i.e. "ma'i valea", the affected person will show several symptoms which include senseless talk, aimless walk and unintelligent behaviour. Included in this broad category are various brain abnormalities ("ma'i o le mafaukau") that may have; (a) been present from birth, (b) resulted from a blow to the head, or (c) a result of illness in another part of the body.

Whilst the prognostic picture for the "ma'i valea" condition is generally seen as bleak, there are therapeutic procedures that are employed by the traditional curers, Western doctors and pastors. In the case of sudden emotional outbursts that may be interpreted as "ma'i valea", the therapeutic efforts may be aimed at bringing the person back under control by calming him down. "If the person is thought to be capable of self-control, he or she may be hit or scolded or taken away from the situation" (Clement, 1982, p.200).

The second Samoan category of mental illness, namely "ma'i aitu", is regarded as a condition that reveals the presence of a spirit (an "aitu") in a person's body. According to Clement (1982):

"An ancestral spirit may become angry at the misbehaviour of 'aiga' (family) members and express dissatisfaction through possession of the erring person or another person through which the 'aitu' speaks to members of the family" (p.201).

Apart from ancestral spirits, people may be persecuted by spirits associated with a particular village. Such spirits are believed to have certain dislikes concerning clothing, hair styles and etiquette patterns. Should someone be diagnosed to have "ma'i aitu" which has resulted from a failure to observe the preferences of a village spirit, he will be taken to someone in the village whom the spirit respects, such as a high chief, so that apologies can be made. In the case of "ma'i aitu" that is associated with one's family ancestral spirits, the Samoan indigenous healer will try to discover the identity of the specific ancestor and to suggest appropriate ritual activities that the patient and his family will be required to perform to restore a harmonious relationship.

According to Clement (1982), the third category of mental illness results from too much emotion or thinking that may propel the afflicted person to externalize his problem (for example, by striking out at those around him) or to turn inward in a self-destructive manner. Several subtypes in this category include worry sickness ("ma'i popole"), strong feelings of depression and sadness ("ma'i manatu"), and angry outbursts or rage ("ma'i ita"). In the case of depression and sadness, the suggested sources of help include friends, relatives, the pastors, and even the hospital.

The second cultural model of mental illness and healing that I will present is the theory of psychological medicine in the ancient Indian medical tradition of Ayurveda. According to Obeyesekere (1982), there are three fundamental assumptions that could be regarded as the foundation of Ayurvedic medicine. First, the universe is believed to be comprised of five "bhutas" or basic elements (atoms), which are ether ("akasa"), wind ("vayu"), water ("ap"), earth ("prthvi"), and fire ("agni" or "tejas"). These five universal elements are also believed to be present in all life including the food that we eat. "As the five elements contained in the food are 'cooked' by the fires of the body, they are converted into a fine portion ("ahara-prasada") and refuse ("kitta" or "mala")" (Obeyesekere, 1982, p.237). Second, the body, comprised of the fine portion of food which has been transformed and refined, has seven components ("dhatus"), namely, food juice ("rasa"), blood ("rakta"), flesh ("mamsa"), fat ("medas"), bone ("asthi"), marrow ("majja"), semen ("sukra"). The latter component is said to be the most highly refined element in the body whose function is to tone the whole organism. . Third, there are three humours (i.e., the universal element of wind, fire appearing as bile, and water appearing as phlegm) that are supposed to be held in a harmonic balance.

According to Ayurvedic medical theory, the harmonic balance of the three humours is essential for the maintenance of physical health. Once this homeostatic condition is upset, these humours become dosas, or "troubles" that will lead to an illness of the organism. The upset "dosa" may also damage one or more of the seven components of the body. The most serious illness conditions are seen to result when all the three humours are upset. As is the case with physical illness, the major cause of mental disorders in Ayurvedic medical is the upsetting of the humours. In other words, the general theory about the interaction of the forces of the universe

with the body and the humours is seen as adequate to explain both the physical and mental conditions of ill health. According to Caraka (cited in Obeyesekere, 1982, p.239), the causes of humoral upset are numerous and may include the following: faintheartedness, mental shock, consumption of improper foods, wrongful bodily activity, other diseases, or those whose "minds have been impaired by the attacks of lust, anger, greed, excitement, fear, infatuation, fatigue, grief, and also those that are injured by trauma" (p.239).

The notions of body functioning and illness as discussed above, have several important consequences as identified by Obeyesekere (1982). First, if the five "bhutas" or elements are found in nature, then nature itself can be a factor in the cause of disease and its cure. The example that is given here is that of an excessive consumption of heat-producing foods which may lead to an excess of bile. Such an excess of bile would lead to the upset of the harmonic balance of the humours, thus leading to illness. A person who is diagnosed to be suffering from this condition will, on the one hand, be advised to avoid heat-producing foods whilst on the other hand a diet of cooling foods to counter the heat will be recommended. Second, if the five "bhutas" pervade all of nature, and if they are also essential for curing, then all substances, including those derived from vegetables (herbs, barks, roots, flowers) are seen as curative. Third, since all the five elements of the universe influence and are also influenced by climatic conditions and seasonal changes, it follows that these environmental forces will have pathogenic and therapeutic effects. Fourth, some congenital factors (known as temperament) may lead to preponderance of a certain humour type which will in turn lead to some form of illness.

According to Obeyesekere (1982), Ayurvedic therapy is directly related to its theory of disease. Since disease (both physical and mental) is perceived to be caused by humoral disequilibrium, the goal of therapy is the restoration of the balance or equilibrium of the "dosas". In this regard, three popular therapeutic methods are deemed appropriate, viz. (i). "hisa kudicci": a therapeutic approach through which head packs containing cooling substances are prescribed for the patient to put on his head for several hours; (ii). "nasna": a therapeutic method involving nasal draining by blowing certain medical preparations into the patient's nostrils. Both "hisa kudicci" and "nasna" are believed to be effective therapeutic methods to unblock the humours which may, as a result of excessive heat, dry up and block the passages to the brain which is

regarded as the seat of the mind. The third therapeutic approach, known as decoction, involves the careful "matching" of certain ingredients contained in vegetables and other food substances so as to calm excessive humour. For example, a patient suffering from high fever is often given coriander (taken to be "cool") combined with ginger (regarded as "hot") to neutralize the body humours.

2.4. Shamanism: a cultural conception of illness and healing

Like other therapeutic systems across the world, shamanism is a culturally determined healing system that is meaningful if understood from within a particular socio-cultural tradition. Shaman is a Siberian Tungus term meaning "one who is excited, moved, raised" (Walsh, 1989, p.2). In most literature, shamanism has been associated with ecstasy that results from experiences of flight and ascent to a high god and by the fact that the experiencing individual is seen to be able to control the spirits. Within this particular context, shamanic states have been identified with ecstatic states such as those of Buddhism, Yoga, and Christian mysticism (Doore, 1988).

2.4.1. Patterns in the calling to become a shaman

In his investigation of the psychological aspects of Indian shamans, Kakar (1982) argues that the budding shaman will go through an arduous process of apprenticeship under the tutelage of a master shaman before he can be seen to be properly qualified. Kakar illustrated his point by focusing one particular case of a young man by the name of Ayata who was apprenticed by his father. Before entering the shamanic profession, Ayata was fond of eating meat and excessively drinking "hadi", the local rice beer. Once selected to become a shaman, his life style changed radically. As Kakar (1982) points out, Ayata:

"... had to live according to the prescribed conduct ('dharma') and rules ('niyam') that govern shamanic training. For instance, Ayata daily performed the ritual worship of the family deities and underwent regular periods of fasting" (p.95).

Apart from being selected by a parent, one can also become a shaman by being directly chosen by a god without the help of human intermediaries. In such a case a budding shaman will be called through what Kakar (1982) describes as vivid dreams which will usually be accompanied by physical and psychological complaints.

Thorpe (1993) reviewed a vast number of ethnographic material and, like Kakar, found that illness and strange dreams are the accepted means of achieving a shamanic condition. All these experiences, Thorpe continued, are understood to be sent from the spirits as an indication that they have chosen the individual concerned. According to Taussig (1987), this transformation into a shaman is an inner healing experience that enables the budding shaman to come into contact with something beyond himself. As he put it:

"The resolution of their illness is to become a healer, and their pursuit of this calling is a more or less persistent battle with the forces of illness that lie within them as in their patients. It is as if serious illness were a sign of powers awakening and unfolding a new path for them to follow" (p.447).

A similar view is expressed by Peters (1989) who wrote that:

"For the future shaman, the early experiences of the SSC (shamanic state of consciousness) entail a radical personality transformation, a break in experiential continuity which fundamentally reorganizes the way of being-in-the-world. This is the 'calling', the beginning of the shaman's transformative journey, the first to wed transpersonal experiences to a career of major spiritual traditions" (p.116).

Once the radical personality transformation has taken place, the shaman is believed to have the gift of easily entering the shamanic state of consciousness (SSC) - a non-ordinary state of consciousness which is synonymous with visualizing or imaging (Walsh, 1989). This point is eloquently articulated by Harner (1990) in his definition of a shaman as "... a man or woman who enters an altered state of consciousness at will to contact and utilize an ordinarily hidden reality in order to acquire knowledge, power and to help others" (p.20). Whilst the validity of such non-ordinary experiences is a debatable issue, Walsh (1989) however is of the view that these non-ordinary states of consciousness are perceived as real by the shaman. As he put it:

"The precise nature (or in philosophical terms the ontological status) of both the realms which shamans experience themselves traversing and the entities they meet is an open question. To the shaman they are interpreted as independently and fully real; to a Westerner with no belief in other realms or entities they would likely be interpreted as subjective creations" (Walsh, 1989; p.5).

2.4.2. The healing process

In his study of the healing traditions in Okinawa, a mountainous Japanese Island, Lebra (1982) identified three stages in shamanic therapy. During the first stage, referred to as negotiating shamanic reality, the shaman has to prove that he is able to control seeing, hearing, or even possession by the spirits. During the second stage, the shaman's therapeutic goal is to establish rapport and determine the cause of a patient's problems. Instead of a patient revealing his illness, the shaman will, through his dealings with the spiritual world know what the problem is. During the third stage as proposed by Lebra, the shaman will prescribe a remedial course of action. Though Lebra identified only three major stages, he points out that there may occur additional stages during shamanic therapy. As he put it:

"... there may occur from time to time additional phases or stages which might be termed contingencies serving to alter typical routines. In some instances the shaman may initiate a new course of action and in other instances respond to the action initiated by the client or by some wholly unexpected turn of events" (Lebra, 1982, p.311).

According to Peters (1989), the shaman carries out therapeutic procedures which flow from his conceptualization of aetiology which, among others, include object intrusion, ancestral displeasure, and evil doing by others. Once the problem has been identified, the shaman will prescribe a remedial programme that will be intended to relieve the client from physical and / or emotional distress. In this regard, a number of procedures are followed. Murphy (1964) made mention of the "brushing" technique as one of the therapeutic procedures used by shamans. Allied to the idea that disease can be transmitted from one person to another or from person to some inanimate or supernatural agent, the "brushing" technique is used to "transfer" the patient's illness to such entities. One instance given by Murphy to illustrate her point is that of an Eskimo mother who asked that her daughter's illness be brushed onto herself. This was done and the daughter reportedly recovered while the mother subsequently died.

The most pertinent questions to ask in the light of Murphy's argument are: What made the shaman to be "effective" in the particular case of the distressed mother and her daughter? Was the effectiveness to do with auto-suggestion and the psychological impact of rituals? If not, what exactly led to the recovery of the young girl. Murphy (1964) sought to address these questions

by suggesting a number of explanations. Firstly, she argued that the procedures followed by shamans have psychotherapeutic elements. For example, apart from offering a causal explanation that will be culturally congruent with a patient's world view, the shaman also provides for group participation during the process of therapy. Secondly, Murphy suggested that the procedures followed by shamans have medical, surgical and chiropractic validity.

Many other authors have also tried to give explanations about the success of shamanism and other traditional forms of healing in the milieu in which they are practised (Harner, 1990; Kendall, 1988; Lebra, 1982; Maskarinec, 1992; Thorpe, 1993; Walsh, 1989). For example, Kleinman and Sung (1979) try to address this issue by looking at the reasons for the success of Taiwanese shamans in treating patients who suffer from different types of distressful conditions. These two authors raise an argument that most traditional forms of healing (including shamanism) tend to have an advantage over Western forms of healing as the latter tend to attend mainly to the patient's sickness (i.e. the primary malfunctioning in biological and psychological processes) whilst paying less attention to the illness (i.e. the secondary psychosocial and cultural responses to disease). In other words, the shaman:

"... treats both the invading ghost (disease) and the symptoms and psychosocial problems (illness) produced by the disease... Problems in [Western] clinical care seem to arise when the practitioner is concerned only with curing the disease, and the patient is searching for treatment of his illness" (Kleinman & Sung, 1979, p.22).

In concluding their argument, Kleinman and Sung proposed a paradigm shift that will result in healing becoming a tool to deal with both a patient's sickness and the resulting illness:

"What is needed in modern health care systems, in both developing and developed societies, is systematic recognition and treatment of psychosocial and cultural features of illness. That calls for a fundamental reconceptualization of clinical care and the restructuring of clinical practice. For, if appropriately trained, the modern health professional can effectively treat both disease and illness" (p.24).

2.5. Concluding remarks

In this chapter, I started by discussing the notions of referential and indexical self with a view to demonstrating how these culturally determined assumptions influence constructions of normalcy and illness. In the second section I gave a brief presentation on mental illness and healing and went further to demonstrate how these clinical realities are deeply rooted in a cultural matrix. In the last section of the chapter I discussed shamanism so as to illustrate the meaningfulness of this healing system if understood from within its cultural context. In conclusion, it could be argued that both Western and non-Western models of mental illness and therapies are ethno-psychiatric systems, one no less culturally constructed, informed and communicated than the other.

CHAPTER 3:

CULTURE, (MENTAL) ILLNESS, AND HEALING IN AFRICA

3.1. Introduction

Before the 1960s, the decade of African independence, it was customary to regard mental ill health as being rare in Africa (German, 1987). Colonial psychiatrists such as Tooth (in Ghana) and Carothers (in Kenya) found evidence from their investigations of hospital populations to support the view that mental ill health was particularly uncommon among Africans, compared with Europeans (Carothers, 1953; Tooth, 1950). According to German (1987), this idea sprang in part from the idyllic philosophies of Rousseau, and in part from the usually unstated belief that mental ill health was part of the price that Judaeo-Christian cultures had to pay for civilization.

In that same pre-independence era, generalizations about Africans included the views that their brains are inferior (Biesheuvel, 1961), that their emotional distress was the short-lived and charming emotionality of the child (Carothers, 1951; Howard & Roland, 1954), and that they lacked a sense of responsibility (Knapen, 1958; Mannoni, 1964). For example, in an study that aimed to investigate the psychological life of North Africans, Porot (cited in Okpara, 1989, p.168) confirmed the myth about the inferiority of the African mind by suggesting that, unlike the European, the North African shows little or no emotion. Porot went on to describe a North African as being violent by heredity and thus unable to channel his aggressive impulses to socially constructive ends. Whilst Porot and other European scholars may be commended for their pioneering psychological studies in Africa, these scholars have been criticized for using European norms as a standard against which African experiences were judged (Bulhan, 1993; Fanon, 1967; Hountonji, 1983; Makinde, 1988; Okpara, 1989; Simone, 1993).

In the last three to four decades, several studies have attempted to overcome the euro-centric bias that was associated with previous studies by applying several strategies that have sought to understand the nature of mental illness in Africa. In the section that will now follow, I review some epidemiological studies on mental illness in Africa. In this regard I raise three questions and briefly discuss some of the epidemiological investigations that were done to try and answer them. Some of the shortcomings associated with these epidemiological studies will be identified and highlighted. These epidemiological studies will be followed by a presentation

of studies that point to the significance of culture in the conception and treatment of mental illness in Africa. The final section will focus on studies that have tried to employ Western psychological theories to explain certain African experiences.

3.2. Epidemiological studies

3.2.1. What is the prevalence of psychiatric morbidity among accessible and easily studied populations?

In the late sixties, German and Arya (1969) did a study of psychiatric morbidity among the students of Makerere University in Uganda. These researchers used the same techniques as Kidd and Caldbeck-Meenan (1966) in a similar study at the Universities of Edinburgh and Belfast. The study by German and Arya indicated an overall prevalence for significant psychiatric morbidity among the students at Makerere to be 10.8%, compared with 11.6% in Edinburgh and 10.2% in Belfast. These figures were further broken down into broad categories of psychiatric diagnosis as follows: 6.7% of the Makerere patients were psychotic, 85.9% were psychoneurotic, and 7.4% were classified as personality disorders. Comparable figures for Edinburgh were 4.6%, 90.2%, and 5.2% respectively; for Belfast they were 2.0%, 91.0%, and 7%. In another study of African students, Jegede (1980) surveyed 145 female and 725 male first year students at the University of Ibadan in Nigeria. The subjects in this study were asked to rate their mental health at the time of the survey and also during the four weeks preceding the investigation. The results indicated that 6.3% of the group tended to perceive their mental health as poor or just fair. Overall, these ratings by the African students were found to be remarkably closer to the prevalence rates of 7 - 16% reported by Segal (1966) in a review of university studies in the western world.

Other studies of accessible and easily studied populations have been directed at the psychiatric status of pregnant women. In a detailed study, Cox (1979) compared 263 pregnant Uganda women with 89 non-pregnant women, using a semi-structured psychiatric questionnaire. He reported that 16.7% of the pregnant women had definite psychiatric disorders, and that a further 14.1% showed possible psychiatric morbidity; the comparable figures for the non-pregnant women were 7.9% and 4.5%. Of the pregnant women, 8% suffered from a depressive neurosis, 2% from a depressive psychosis, 3.4% from an anxiety neurosis, and 1.9 from a phobic neurosis. The findings by Cox confirm an earlier report by Assael, Namboze, German and Bennet

(1972) that 24% of pregnant women in the same population showed evidence of psychiatric morbidity, the bulk of which was of a depressive sort. It is of interest to note that both these Ugandan studies report prevalence rates in excess of rates reported from Europe: 17.1% in Sweden (Nilsson and Almgren, 1970), and 16% in Britain (Kumar and Robson, 1978).

3.2.2. What is the prevalence of psychiatric disorder among general hospital out-patients?

One of the older, but most detailed studies to address this question was carried out in Ethiopia by Giel and Van Luikk (1969). This study indicated that 18.5% of the general out-patient patients attending a teaching hospital in Addis Ababa were primarily suffering from psychiatric conditions, compared with only 9.5% diagnosed as suffering from infectious diseases. In a more rural population served by a provincial general hospital, only 7% of the general out-patients were found to be psychiatrically ill, while 28.7% showed evidence of infectious disease. Finally, at a rural health centre serving a largely self-referred population, 19.5% of out-patients were deemed to have psychiatric disorders, compared to 17.1% who were found to suffer from infectious disease.

In a study that focused on admissions to a general clinic in Nigeria, Mbanefo (1971) found that 15% of the patients were diagnosed as having a psychiatric disorder. In another study done in a rural area in Kenya, Ndeti and Muhangi (1979) did a survey of the patients who were seen at an out-patient clinic over a period of 30 days. Of the 140 patients, 20% were found to be psychiatrically disordered, and 59.3% physically ill; with the diagnosis of the remaining 20.7% classified as uncertain. The majority of the psychiatric cases were found to show anxiety and depressive symptoms.

3.2.3. What is the prevalence of psychiatric conditions in samples drawn from African populations?

Several investigations have been done in an effort to answer this question (Ilechukwu, 1991; Makanjuola, 1985). In this brief review I will look at two such studies that have been done in different parts of Africa. In an attempt to establish data on psychiatric morbidity in an African setting, Orley and Wing (1979) conducted field work in rural Uganda, using the Present State Examination (a standard system of defining, eliciting, and recording psychiatric symptoms

developed by Wing & Stuart, 1978) which was translated into Luganda - one of the several indigenous languages spoken in Uganda. The survey was carried out in two villages: the first in Bulemezi County, 48 kilometres from Kampala; the second in Kyaddondo County, 16 kilometres from Kampala. A total of 206 adults were used as subjects in the survey. In brief, 4.9% of the total population showed definite psychiatric syndromes, with an additional 20.4% of the population showing evidence of psychiatric distress at threshold level. There was no difference between the proportions of each sex showing definite psychiatric symptoms, and little difference at the threshold level. Combining all cases at threshold level and above, 27% of the women and 24% of men showed evidence of psychiatric disorder. In comparison, the authors reported that in a suburb of South-East London 11% of women showed evidence of psychiatric disorder at the threshold level and above. The results of Orley and Wing's study suggested a point prevalence of psychiatric morbidity in Uganda to be at least twice that found in South-East London.

Overall, the epidemiological studies that have been reviewed in the preceding pages communicate one clear trend: the extent of mental illness in Africa is at least as substantial as in other parts of the world where data have been obtained, and in some cases there is even evidence which suggests that morbidity rates may even be greater. Whilst these epidemiological studies are useful, Kleinman (1987; 1988) warns against a tacit professional ideology in cross cultural studies which functions to exaggerate what is universal whilst at the same time de-emphasizing what is culturally particular. This bias toward "discovering" cross cultural similarities can be illustrated by making reference to two related international studies. In the first study, entitled: *"International Pilot Study of Schizophrenia"*, the World Health Organization (1973) sought to demonstrate that schizophrenia is a universal psychiatric illness category that could be detected with the same degree of certainty in all cultures if standardized diagnostic techniques are applied. Using non-epidemiological, clinic-based samples drawn from a wide range of societies, the investigators applied a template of symptoms to identify groups of patients who seemed similar. As expected, the study found that core symptoms of schizophrenia tended to cluster together in more or less the same way in Western and non-Western, industrialized and non-industrialized societies.

Inspired by the *International Pilot Study of Schizophrenia* Sartorius, Jablensky, Korten, Ernberg, Anker, Cooper and Day (1986) later did a similar study but one which began in an epidemiologically more rigorous manner with first contact incidence sample of patients with psychotic disorder. Using a sample of 1300 cases drawn from twelve centres in ten different countries, Sartorius and his colleagues found that patients with a diagnosis of schizophrenia in the different populations from where the samples were drawn share many features at the level of symptomatology. What is interesting about this study is the fact that the cross cultural differences in symptomatology were de-emphasized. According to Kleinman (1988), a more valid interpretation of epidemiological data can only emerge when both the "universal" and the culturally particular viewpoints are reviewed together.

3.3. Cultural studies

With the increasing evidence of the role of culture in people's notions of health, there are many studies that have sought to investigate the beliefs and practices associated with mental illness in various African communities. These studies have employed methods ranging from highly quantitative survey techniques (Abasiokong, 1981; Peltzer, 1987) to ethnographic participant observation and open-ended interviews (Feierman, 1981, Morikanyo, 1989), whilst others have combined both qualitative and quantitative methods (Bierliech, 1995). The following discussion reviews some of the popular patterns of psychological distress and considers how culturally appropriate explanatory models are often applied by African communities to make sense of these experiences.

3.3.1. African notions of mental illness

According to Gelfand (1979), the Shona people of Zimbabwe have a clear idea of what constitutes "kupenga" (mental illness). A person who is mentally ill will show one or more of the following symptoms: senseless talk and action, restlessness, violent behaviour, and social withdrawal. As soon as these symptoms are noticed, the disturbed person will be taken to a "nganga" (indigenous healer) who Gelfand regards as the cornerstone in Shona medical practice. Three broad factors are seen as causes of mental illness in this community. First, "vadzimu" (the spirits of grandparents and parents) are seen as responsible for most cases of mental illness. In this case, the mental illness will be interpreted by a "nganga" as a way the "vadzimu" are trying

to communicate with the living. Persistent disregard of these ancestral messages is interpreted as a reason for ancestral wrath which, in extreme cases, may result in death of the sufferer. Second, the Shona attribute mental illness to witchcraft ("kuroiwa"). In this case, the mental illness may be seen to have resulted from a spell that was cast by a witch. "Kupenga kwechitsiko" is one category of mental illness which, according to Gelfand, is a hysterical state which is characterized by the display of mental imbalance. This disturbance is believed to improve when the victim is left alone or when he leaves the village. Three other categories of mental disorders which are attributed to the activities of witches are identified. These are "rema" (mental retardation), "mamhepo" (a mental disorder in which the patient mimics a particular animal), and "benzi mazurazura" (a mental disorder in which the afflicted becomes violent to others). The third causal explanation for mental illness is strain or severe worry. According to Gelfand, a person who has stolen something may begin to fear that he will be discovered. This continued fear and worry may lead to a mental breakdown. Apart from the three causal factors (ie. "vadzimu", witchcraft, and excessive worry), the Shona people also attribute (albeit to a lesser extent) mental illness to factors like incorrect use of magical medicines, ghosts ("chipoka"), and improper development of the brain.

Among the Bambara of Mali, the fundamental concepts regarding health and sickness are based on the idea of balances and imbalances between the components of the organism, and between those components and elements of nature such as earth, water, fire, and metals, and heavenly bodies such as sun, moon, and stars (Koumare, 1983). Each element is seen as capable of exerting a specific influence on certain organs. Thus from birth, the newborn infant is subject to the control of elements of nature, and survival depends on the capacity to establish equilibrium in an environment containing both favourable and unfavourable elements. The notion of equilibrium is also reported in the case of humoral medicine as practised in Morocco. In a paper entitled: "Cold or spirits? Choice and ambiguity in Morocco's pluralistic medical system", Greenwood (1981), points out that according to humoral medicine as practised in Morocco, there are hot and cold foods and environmental factors, whose imbalance in the body produces hot or cold illnesses that are treated by foods of the opposite quality.

In a study that focused on the northern region of Malawi, Peltzer (1989) asked 116 patients to describe the symptoms and etiological factors associated with a spirit disorder known as "vimbuza". Half of this sample was drawn from a rural area whilst the other half came from an urban area. There were 23 symptoms descriptions that were given by the patients. Of these descriptions, 13 were found to be similar to those observed in conversion or dissociative disorders whilst seven were compatible with those observed in neurotic depression. Using a conventional nosological system, Peltzer described "vimbuza" as a psychoneurotic condition that manifests mainly as a conversion or dissociative disorder. Whilst symptom descriptions were compatible with those identified in psychoneurotic disorders, Peltzer found that the etiological explanations of "vimbuza" that were given by the subjects were in keeping with some of the prevailing cultural notions of ill health. Four such etiological explanations were given for "vimbuza": These are (i). bad ancestral spirits; (ii). the "vimbuza" may naturally come by itself; (iii). too much thinking over personal problems; and (iv). witchcraft.

Several other authors working in Africa have also written about some indigenous African categories of psychological disorders (Didilon & Olandzobo, 1989; Imperato & Traore, 1979; Morikanyo, 1989; Peltzer, 1995; Prince, 1974; 1989). For example, Nzwei (1989a), identifies six categories of mental illness among the Igbo people of Nigeria. The first category of mental illness, known as "onye ala" is regarded as the most severe and is likened to hebephrenic schizophrenia. Even though this is the most severe form in the Igbo classification of mental illness, the individual suffering from this disorder is considered harmless. The second and third categories known as "isi mgbaka" and "isi mmebi" respectively, are also psychotic illnesses though their prognosis is better as compared to "onye ala". The fourth category of mental illness identified is known as "agwu". A person suffering from this disorder is said to be possessed, and during this period of possession the patient will act irrationally and irresponsibly. The fifth category of mental illness which is known as "akaliogoli", is similar in manifestation to the sixth category (namely "efulefu") so much that these two concepts are even used inter-changeably. Someone afflicted with "akaliogoli" or "efulefu" is not really ill, but is said to have a defect in the realm of socialized behaviour. Such a person is believed to have failed, in the process of development, to introject parental norms and values.

3.3.2. Cultural approaches to diagnosis and healing:

As in Western medicine and psychiatry, an indigenous African healer has two critical functions to perform when he encounters someone who may present with any of the above culturally constructed psychological disorders: he must attempt to identify and diagnose the particular phenomenon experienced by the patient, and he must link the patient's idiosyncratic experience with a culturally meaningful theory, which will enable him to reintegrate the patient back into the cultural mainstream (Awanbor, 1982; Kleinman, 1980). The indigenous healer must redefine the vague complaints presented by the patient in terms of some causal agent like anger of the ancestors or the violation of a specific taboo. By narrowing down the cluster of symptoms and complaints and giving a focus on something (a diagnosis), the indigenous healer is in a position to begin to define the kinds of inquiries that must be made to further explore the problem.

In order to identify the problem during this crucial diagnostic stage, the indigenous healer employs some assessment procedures which constitute a critical part in the induction of a treatment process (Kiev, 1989; Peltzer, 1989; 1995). With little or no history of the problem given by the patient, the indigenous healer will use assessment devices to reveal the nature and extent of the patient's problem. In this regard, various diagnostic methods like divination bones (Mendonsa, 1982), and dream interpretation (Chavunduka, 1995) are used. According to Kiev (1989), divination by some indigenous healers in Nigeria is a complex process that involves the recitation of some incantations. These are 206 elaborate poems which are seen to evoke a wide range of emotions in the patient, such as fear, guilt, remorse, hope, and a positive expectation of help. Makhubu (1978), made mention of yet another method of diagnosis that is used by indigenous healers in Swaziland. A mind altering drug is given orally or as a nasal snuff to the patient. During the induced altered state of consciousness, the patient will then talk about his sickness and about his whole life. The potential danger in the use of hallucinogens and other mind altering drugs by indigenous healers has been documented in the literature (Green & Makhubu, 1984; Neuman & Lauro, 1982).

After establishing the nature of the problem and giving a culturally compatible diagnosis, the indigenous healer will apply some therapeutic procedures in order to ameliorate the condition of ill health. The comprehensive approach of indigenous healing is evident in treatments given

to the body, to social and spiritual relationships, and to certain psychic states, such as guilt and anxiety. Treatments may be directly curative or may include protective or preventive factors (Corin & Bibeau, 1980; Nzwei, 1989b); they may just involve the healer and patient or they may involve the patient's family and community as well (Awanbor, 1982; Figge, 1989; Kiev, 1989). Whatever their form, all treatments are either natural or ritual, and most therapies contain elements of both (Corin & Bibeau, 1980; Koumare, 1983).

On the natural (or physical) level of intervention, drugs and other physical methods of treatment are used. Several authors have explicitly stated that herbal remedies are important in indigenous African healing. Prince (1968) noted that *Rauwolfia vomitoria* was regularly used as a tranquillizer in Nigeria and other parts of Africa. Other optimistic claims about the positive pharmacological properties of indigenous herbs have also been made. For example, a study commissioned by the World Health Organization (1977) was carried out at the University of Science and Technology in Ghana. Led by Ampofo, a Ghanaian medical practitioner, this investigation was in the form of a case study that looked at a 45 year old woman who had diabetes with a fasting blood sugar of 370mg per 100ml. Deciding not to give her any Western drugs, he put her on *Bridelia ferruginea* - an indigenous African herb belonging to the Loganiaceae family. After one week, the fasting blood sugar reportedly fell to 25mg per 100ml and became normal after 11 weeks. These results were interpreted to mean that there are some positive medicinal properties in the indigenous African herbs.

Indigenous healers prepare their remedies in numerous and varied forms (such as powder, solution, soup, ointment) depending on the way they are to be administered, the patient's wishes, the limitations of the raw materials (for example, it is difficult to prepare a powder from fresh leaves) and the like. According to Edgerton (1979), the most frequently used ways of administering the remedies are oral, dermal, nasal, anal, vaginal, and auricular. Sometimes the medicine is given as nose or eye-drops or as a potion for the patient to drink. At other times powder is applied to incisions, having an effect similar to a hypodermic injection, or is inhaled in a way similar to the inhaling of an aqueous solution spray. Also, the remedies may be worn in ornaments. Kiev (1989), is of the view that a number of restrictions in traditional medicine coincide with the contraindications cautioned for some remedies in Western medicine. For

instance, no alcohol is to be consumed by patients receiving certain traditional treatments. Other restrictions are seen as more symbolic in nature, such as prohibiting an epileptic child from eating fowl because convulsions evoke the winged movement of the birds (Corin & Bibeau, 1980).

On the psychological level, therapy is based on rituals and a group of symbols and beliefs, some of which are general in scope whilst others are more specific to a particular society or ethnic group. Rituals may be peripheral, integral, or universal in the overall therapeutic strategy. Peripheral rituals reinforce the treatments that use herbal and physical remedies. For example, just before treatment is begun, the indigenous healer may engage in a brief ceremony such as a prayer to the ancestors. A ritual may be integral to treatment and thus have its own therapeutic goal. As part of treatment, for example, a patient may be advised to go and have a purification bath in a river. Rituals that are all-encompassing or universal to a therapy are calculated to let ancestral spirits possess an individual and, through that possessed individual, to communicate their needs and intentions to members of a family or the community. What is remarkable about the universal rituals, when compared to the first two types, is that they facilitate some form of initiation through which the experiencing individual is integrated into a community of people experiencing a similar relationship with the spiritual world.

3.4. Psychological explanations

Whilst descriptions of local concepts of illness and healing dominate the literature on indigenous healing in Africa, several other studies have been done to identify and articulate the underlying psychological principles associated with this health care option. I will discuss five such principles which appear to have been extensively covered in the literature. First; according to Zemleni (1977), indigenous healing is a process of many steps, beginning before any healer is consulted and then evolving through different types intervention. Regarding its commencement before any indigenous healer is consulted, Abasiokong (1981), for example, pointed out that it is when the patient's family members arrive at a "primary consensus" regarding the hypothetical meaning of the illness (and hence the choice of healer to be consulted) that the first step towards cure is taken. Consulting an indigenous healer strengthens this process, since it is, in a sense, a seeking of "secondary consensus" from the wider community which he (the indigenous healer) represents, and the patient is encouraged to feel even more that his illness is of concern to others. As a result

of the active involvement of family members, the indigenous healer's therapy, therefore, can not be reduced to a dyadic process between himself and the patient. It is part of a set of interrelationships in which four sets of actors take part: the healer and his auxiliaries; the patient and his family; the spiritual powers; and those other community members who assist (Atuodo, 1985; Maclean, 1986, Willis, 1986).

Second, many authors have generally placed suggestion as the most important psychological principle underlying all forms of indigenous healing in Africa (Awanbor, 1982; Twumasi, 1979; Wittkower & Warnes, 1974). Prince (1979) identifies a few elements of suggestion, for instance, the indigenous healer's power which is rooted in his links with the spirit world, the use of sacred formulae when treatment is given, and abundant stories about patients who have previously been cured. Also falling within the category of suggestion can be "scapegoating", i.e. the transferring of illness and other evil to an animal or other appropriate object. These suggestive elements are seen to heighten the patient's expectation whilst at the same time encouraging him (the patient) to be committed to the process.

The symbolism of ritual constitutes a third therapeutic principle for many scholars, although they differ in their explanations for this. Turner (1973) has pointed to the significance of ritual symbols on both the cultural and emotional levels as they are seen to provide a representation of the dominant social and moral order while also appealing to the senses. Prince (1974) has suggested that the symbols associated with the rituals may be an almost theatrical representation of the desired healing. For Awanbor, (1982) the symbolic aspect of healing rituals allows the patient to locate his illness and its causes within his cultural framework. Awanbor further suggested that symbols work at an unconscious level because they are related to such fundamental questions as birth and death, fusion and separation. It is not only within the mind of the patient that indigenous healing techniques operate, however. Indigenous healing is relational, i.e. it involves the interaction of many people and the manipulation of the social environment (Ataudo, 1985; Maclean, 1986). This socio-therapeutic activity may occur in the patient's home environment or in a special therapeutic set up that will have been suggested by an indigenous healer.

A fourth underlying psychological principle commonly identified in indigenous African healing is therapy within possession cults. Possession cults constitute one of the key aspects of traditional African psychotherapy and provide both treatment for patients and training for therapists, the latter often deriving from the former. When symptoms are attributed to a potentially "good spirit", this is often taken to indicate that initiation into possession is required, and that in turn usually implies joining a group or cult made up of healers and former patients. The common view of possession cults is that they principally serve persons who are socially marginal, and provide aid of three main kinds (Crapanzano, 1977). They relieve anxiety and tension; they support the individual's demand on his family milieu by attributing them to a possession spirit; and they offer an increase in social status because of the prestige acquired by being possessed by an important spirit. Possession cults are also seen as essentially conservative or homeostatic, acting as a safety valve for disadvantaged sections of society (Frigge, 1989; Prince, 1979). Some authors attribute a more dynamic social role to possession cults. They are seen as a channel for social mobility by allowing "the voice of women" and other oppressed sections of community to be heard (Corin & Bibeau, 1980). For Awanbor (1982), the ceremonies associated with the possession have an ego-strengthening effect as they provide moments of ecstasy or complete peace on the patient. This results in the patient becoming emotionally better equipped to deal with the stressful events in his life. In his authoritative book entitled: "Case studies in spirit possession", Crapanzano (1977) pointed out that possession has both expressive and instrumental functions, the latter dealing with conflict resolution and the former dealing with personal identity. A possessed person is often allowed to assume behaviours which are inconsistent with, or even opposed to, his normal personality. Such "role playing" is seen to encourage the expression of suppressed and repressed aspects of personality in a symbolic and socially acceptable manner.

The community as a therapeutic milieu constitutes the fifth psychological principle that underlies indigenous healing in Africa. Awanbor (1982) identifies four therapeutic ideologies and principles that guide the establishment of therapeutic communities. These are: rehabilitation, permissiveness, democratization, and communalism. According to Awanbor:

"In an African community where the equilibrium of the traditional life pattern is yet relatively undisturbed, these four basic elements of a therapeutic community are a natural part of the community network and only await a systematic rechanneling toward therapeutic ends" (1982, p.211).

It is these therapeutic ideologies and principles that Lambo (1974) tried to re-channel when he set up the pioneering Nigerian Aro village treatment centre. In this therapeutic community, the treatment of patients is a blend of indigenous African healing and Western psychotherapy and medication. Patients admitted to this centre for treatment were required to be accompanied by a predetermined number of close relatives. In addition to medication, various social activities like watching movies, social dancing and church services are prescribed with a view to encouraging the patient to interact with others. In this way, a smooth therapeutic programme that accommodates the social, psychological, and physical aspects is provided to the patient and the relatives.

3.5. Concluding remarks

In this chapter I have given an outline of the literature pertaining to culture, illness and healing within an African context. The first section addressed this issue from an epidemiological basis whilst at the same time pointing to some of the difficulties that are associated with such endeavours. In the second section, I looked at the cultural explanations that are advanced by African communities not only to give meaning to conditions of mental ill health, but also the strategies that these communities will employ to restore what is culturally understood as good health. Given the vastness of Africa and the heterogeneity of its cultures, I have sampled only a few explanatory African models of mental illness and healing in countries like Zimbabwe and Mali. In the third section I have reviewed some studies that have employed Western psychological theories to render the cultural experiences of illness and healing in Africa cross-culturally meaningful. In this regard five therapeutic principles that are operative in indigenous African healing systems have been identified and discussed. In the next chapter I will extend the discussion on cultural notions of mental illness and healing by focusing specifically on South Africa.

CHAPTER 4

INDIGENOUS HEALING IN SOUTH AFRICA: CULTURAL AND PSYCHOLOGICAL THEORIES

4.1. Introduction

This chapter addresses itself to two important aspects about indigenous healing in South Africa. In the first part of the chapter, I will give an outline of the literature on the attribution of cultural meanings to the experience of illness and the healing approaches that are subsequently mobilized to restore normalcy. In this regard a number of topics, including indigenous explanatory models of illness and some of the diagnostic and therapeutic methods used by indigenous healers will be discussed. An attempt will also be made to give a distinction between the various categories of indigenous healers even though there is no consensus in the literature on this subject.

In the second part of the chapter, I will discuss some of the prominent South African studies that have offered psychological explanations to various aspects of indigenous healing. Firstly, I will consider the work of Vera Buhrmann, a psychiatrist and Jungian psychoanalyst who devoted a lot of her time trying to understand some rituals and ceremonies that are found among the Xhosa speaking people of the Eastern Cape. I will illustrate how she employs some concepts of Jungian psychology to interpret these and some experiences like dreams and "thwasa" (a process through which an individual becomes an indigenous healer). A brief section on some of the strengths and shortcomings in her work will also be presented. Secondly, I will consider Schweitzer's phenomenological studies on three topics, namely, the "thwasa" experience, dreams, and diagnosis and treatment in traditional healing. Some of the difficulties inherent in his studies will be identified and articulated. Thirdly, I will consider two studies that Edwards carried out in the KwaZulu Natal province. In these studies, he has sought to compare indigenous healers and Western psychologists in terms of their interview and treatment methods. Some of the contributions that Edwards makes are highlighted while the difficulties of making such comparisons are also pointed out. Finally, I will present the works of Mkhize and Mkhwanazi - two authors who have (in their individual studies) tried to compare indigenous healing to experiential and client centred therapy approaches. Again some of the contributions and shortcomings of their studies will be identified and highlighted.

4.2. Indigenous notions of mental illness and treatment

4.2.1 Explanatory models

(a). Poisoning: Buhrmann (1984a) and Ngubane (1977) mention poisoning as one of the popular etiological factors advanced to explain some physical and psychological complaints presented by African patients in the Nguni communities. It is believed that, at times, some people are driven by jealousy and evil intentions to an extent of poisoning those they envy or hate. Within the context of indigenous African culture in South Africa, such poisoning is believed to cause physical symptoms relating to musculo-skeletal and gastro-intestinal complaints which can only be treated by herbal remedies prepared by an indigenous healer.

In Western medicine and psychology, the above physical and psychological symptoms would probably tempt a clinician to give a diagnosis of somatoform disorder if a medical basis for the condition can not be established. Medication and psychotherapy might then be prescribed.

(b). Pollution: Another view among the indigenous populations of South Africa is that events associated with the beginning and end of life have the capacity to decrease an individual's resistance to various types of illness. Ngubane (1977) and Monnig (1967) wrote about this etiological explanation and went further to point out that a person may also be vulnerable to misfortunes and accidents once this capacity to resist has been lowered.

Hammond-Tooke (1989) gives a detailed account of a pollution state among the Sotho speaking people of the Northern Province. Known as "sefifi" or "senyama" (roughly translated to mean darkness or bad luck in English), this condition results from having contact with a widow or widower who has not performed the necessary cleansing rituals. Symptoms manifested by people with "senyama" include loss of hair, coughing, swelling of body and psychological conditions like extreme social withdrawal. Hammond-Tooke (1989) goes further to describe treatment for people so afflicted as follows:

"A structure of poles is made around a fire and covered with a blanket ... A pot with an infusion of herbs is placed on the fire and 'magakabje' [stone] crystals, heated in the fire, are placed in the mixture. The vapours are then inhaled" (p.98).

The above quotation gives the impression that the medicated vapour that is inhaled has the capacity to clean the "polluted" body of the person who is having "senyama". Though no scientific justification can be found for the notion of pollution and its treatment, some interesting parallels can be drawn between modern studies of immunology and certain aspects of the "senyama" condition. Western medicine, for example has established that exposure to certain types of pathogens can weaken or even destroy one's immune system, thus making such an individual vulnerable to various diseases. Thus both the germ theory and indigenous explanations of a pollution state identify a somewhat similar causal pattern that involves a decrease of physical (and psychological) resistance.

(c). Environmental hazards: In a study conducted in 1971 on 100 households comprising 1182 Nyuswa Zulu people (the Nyuswa reserve lies within the Valley of Thousand Hills, about 50 kilometres from Durban), Ngubane (1977) identified a condition known as "umeqo" (literally meaning the act of stepping over a harmful substance). Understood as a dangerous cultural and environmental illness that commonly afflicts pregnant women and children, "umeqo" is believed to come about in two main ways. First, the movement over the ground or through the atmosphere of human beings, animals, birds, poisonous snakes and lightning are believed to leave either visible or invisible tracks which create an environmental health hazard. Second, witches or jealous people may deliberately place harmful medicines in the pathway of people they hate or envy.

Some of the symptoms of "umeqo" that Ngubane (1977) identified include painful or swollen joints and hemiplegia. Hammond-Tooke (1981) reported a clinical condition similar to "umeqo" among the Sotho speaking people of the Northern Province. Known as "sefolane" (literally meaning swollen legs or arms), this distressful condition is believed to be brought about in essentially the same way as "umeqo". Both Ngubane (1977) and Hammond-Tooke (1981) indicate that diagnosis and treatment of this environmental illness is normally done by an indigenous healer who will usually prescribe herbal preparations to cleanse and strengthen the afflicted person. Apart from the herbs, there are several elaborate strategies that have been ritualized in the form of taboos which appear to serve a preventive function.

According to Gumede (1990), the indigenous beliefs, customs and practices against environmental hazards serve a definite public health function. One example that Gumede gives to substantiate his claim is that of a Zulu custom that dictates proper disposal of hair. The Zulu speaking people hold a belief that hair which is cut and left in the open without being properly disposed of will be blown away by the winds. Such hair may subsequently come into the hands of a witch who is believed to have the capacity to doctor the hair never to grow again. Gumede explains this custom from a public health perspective by advancing a view that it is an hygienic exercise through which people prevent loose hair from being tossed about by the winds and inhaled with the air. Such loose hair particles, he continued, can settle on the delicate mucous membranes of the nostrils, throat and larynx, thus causing respiratory problems and infections. Another interesting example that Gumede (1990) gives is the taboo that prohibits children from counting the stars and gazing at the moon. Such prohibited activities are believed to lead to bed-wetting - a condition that will prompt the parents of the afflicted child to solicit the help of an indigenous healer. The public health explanation that Gumede attaches to this taboo is that it protects children's eyes from strain.

(d). Ancestral wrath or displeasure: Within the context of indigenous African culture, the presence of ancestors is the most important factor in maintaining good health in people and animals (De Villiers, 1985; Edwards, Grobbelaar, Makunga, Sibaya, Nene, Kunene & Magwaza, 1983; Hadebe, 1986; Hammond-Tooke, 1989; Ngubane, 1981; Wessels, 1985). Ancestral influence is seen to be benign and all embracing as these supernatural beings are perceived to be present at all times, protecting the homestead and following their descendants wherever they go (Buhrmann, 1984a; 1984b; 1989; De Villiers, 1985). Besides endorsing the idea of the omnipresence of the ancestors, Makwe (1985) further argued that these supernatural beings are protective in the sense that they are concerned with the health, prosperity or good fortune of their descendants. In other words, one can speculate that harmonious relationships between ancestors and the living are reflected by conditions of good health. When these positive relations are disrupted, ancestral protection will be withdrawn thus making the descendants vulnerable to illnesses or even death.

Buhrmann (1984a) identified several Xhosa customary activities, the commission or omission of which may invoke ancestral displeasure and subsequent withdrawal of protection:

- i). Simple customs or the requests of the ancestors, such as brewing of beer, were not fulfilled. This is interpreted by ancestors as lack of respect by the living;
- ii). Some particular ritual like "ukubuyisa" (a ritual performed to bring a deceased person back home as an ancestor) was omitted;
- iii). A ceremony was performed without following the essential ritual details as prescribed by the ancestors;
- iv). There has been unethical or proscribed behaviour by a member of the family or clan. Examples here include incest and family discords.

Illnesses that may be attributable to ancestral displeasure include infertility in women (Hammond-Tooke, 1989), compulsive behaviour (Buhrmann, 1984a), sickness in children (De Villiers, 1985; Sodi, 1987) and a psychotic-like condition known as "phambana" (Buhrmann, 1979; 1982a; 1990). According to Schweitzer (1977a), a "phambana" person is believed to show the following clinical features: idleness, extreme aggression, social isolation, inappropriate laughter and crying, disregard for customs, running around aimlessly, and answering questions irrelevantly. Using a phenomenological approach to explicate the meaning of "phambana", Schweitzer (1977a) went further to give a favourable prognostic picture of this condition which he interpreted as a "punitive illness" (by offended ancestors) that can be ameliorated by re-establishing the harmonious vital link between ancestors and the living.

(e). Witchcraft: In his study of the Sotho speaking people, Hammond-Tooke (1975; 1981) covers the subject of witchcraft and goes on to give a detailed description of a witch as some "crafty" individual who can change shape, become invisible, or make use of agents or a familiar spirit known as "tokoloshe" when he is in a mission to harm others. In this transformed state, the witch can "fly through the air in a flash of time, can enter a hut through a crack in the door, or even plunge (his) victims into a deep sleep so that they can be sent wandering out in the night..." (Hammond-Tooke, 1981, p.97).

One of the most feared illnesses that are believed to be inflicted by witches on their victims is known as "amafufunyana" (Buhrmann, 1977, 1982a; 1983; Cheetham & Cheetham, 1976; Edwards, Cheetham, Majozi & Lasich, 1982; Schweitzer, 1980). Through the manipulation of some mystical forces, and by using certain concoctions, witches are believed to inflict this dreadful illness in their victims. According to Schweitzer (1977a; 1977b), "amafufunyana" is characterized by listlessness, loss of appetite, insomnia, bad dreams, frigidity, and anger without reason. One other feature about "amafufunyana" is that it is believed to be so contagious that even the best of indigenous healers will try to avoid a patient presenting with this condition, lest the indigenous himself will get afflicted (Buhrmann, 1984a). Compared to "phambana", "amafufunyana" is seen as difficult to treat (Schweitzer, 1977a).

4.2.2. Diagnosis

(a). Approaching the indigenous healer: The usual procedure for an individual or family struck by misfortune is to approach an indigenous healer. Like Western oriented health practitioners, indigenous healers also favour certain environments where they function optimally. According to Schweitzer (1977a), a special hut in the homestead of the indigenous healer will usually be used as his consulting room. Buhrmann (1984a) added that consultations may also take place in the open next to a cattle kraal. According to Buhrmann, the indigenous healer's consulting rooms and the place next to a cattle kraal are believed to have the protection of the ancestors. It could thus be speculated that the choice of a consultation venue is made by the ancestors or by the indigenous healer in active consultation with them.

In special cases, like when a patient is very ill, the indigenous healer may be asked by the family to make a home visit for the purpose of consultation. In this case, the environment and place is strange for the indigenous healer. Buhrmann (1984a) believes that such special consultations are difficult as the indigenous healer will not be very close to his ancestors who are supposed to guide him during consultation sessions. Whatever the venue for consultation with the indigenous healer, the patient will usually be accompanied by family members. In the event of the family not being available, the patient will be accompanied by close friends (Bodibe, 1992; Broster, 1982; Cheetham & Griffiths, 1982).

While a Western oriented health practitioner will work out a diagnostic and treatment plan on the basis of the history of the illness as supplied by the patient, the indigenous healer on the other hand rarely asks for such background information (Kruger, 1974; Mkhize, 1981; Sodi, 1987). Instead the latter will, through his spiritual dealings and various diagnostic procedures:

- i). seek to establish what the client's problem is and how it came about;
- ii). explain to the consultees as to when the problem started and why the illness attacked a particular person and no one else;
- iii). in the case of suspected witchcraft, also give an explanation as to who is responsible for the sickness;
- iv) interpret messages from the ancestors to patients whose conditions are believed to be caused by the supernatural forces; and
- v) establish the type of intervention programme that should be adopted. (Sodi, 1987).

(b). Diagnostic methods: Like their Western counterparts, indigenous healers have over the years developed various methods to establish the cause and treatment approaches for the various conditions that their clients present with. A review of the literature shows great variations in the diagnostic procedures based on the factors like the indigenous healer's preferences (Kruger, 1978; Mendonsa, 1982), geographical location (Bodibe, 1992; Farrand, 1980; Mkhwanazi, 1986), and the nature of training received (Griffiths & Cheetham, 1982; Mkhwanazi, 1989). A diagnostic method like "ditaola" (divination bones) may be used alone or in combination with other methods depending on the nature of the patient's complaints (Mendonsa, 1982; Monnig, 1967).

Apart from their popularity in South Africa (Buhrmann, 1984a; Hammond-Tooke, 1981; 1989; Ngubane, 1977;), divination bones are also reported to be used in other parts of Africa (Anderson & Frantz, 1986; Gelfand; 1979; Makhubu, 1978; Mendonsa. 1982). While undergoing treatment, the trainee indigenous healer is taught the composition, characteristics and meaning attached to each bone and the positioning of the bone in relation to the other bones. Upon completion of training, the graduate indigenous healer will acquire his own set of divination bones that will be used in his practice.

What ultimately constitutes a complete set of divination bones differs from one healer to the next and from area to area. Whatever the composition in terms of the number and types, divination bones are believed to perform several functions. For example, in his investigation of the cultural practices of the North Sotho speaking people, Monnig (1967) gave the following description of the functions of the divination bones:

"[The divination set] indicates to those trained in its use the answer to any question or meaning of any situation. It can deduce whether the cause for a mishap should be ascribed to witchcraft or to the dissatisfaction of the ancestors spirits ... It indicates the cause of a disease, the nature of the disease and the curative methods to be administered. It can predict rain or drought, the course of a war, the results of a journey or any other future event about which one wishes to know, as well as the precautionary measures which should be taken to ensure the desired results ..." (p.81)

What Monnig is trying to say here is that the divination bones are much more than just a clinical instrument. In other words, this set of diagnostic bones may also be used to predict economic, social and political problems as well as giving an indication of how these problems can be overcome. One implication here is that the scope of an indigenous healer's work is much broader than that of a Western trained health practitioner.

A question that may be raised at this point is whether divination bones can be likened to some projective tests like the Rorschach and Thematic Apperception Test that are used by Western oriented psychologists. This question is even more pertinent if one considers Coleman, Butcher and Carson's (1980) explanation of projective theory:

"An assumption underlying the use of projective techniques is that in trying to make sense out of vague unstructured stimuli, individuals project their own problems, motives and wishes into the situation" (p.605).

The above quotation suggests that the patient is the one who makes sense out of the stimulus presented. The psychologist's role is thus to interpret the verbal or written statements given by the patient. On the other hand, the indigenous healer will take an active role in communicating the patient's wishes, motives and problems on the basis of the picture that

emerges from the divination bones. In other words, whereas the patient "reads" the stimulus to the psychologist who is going to make the interpretation, the indigenous healer on the other hand "reads" and interpret the stimulus to the patient. It will thus seem that even though both the psychologist and indigenous interpret projective material, they do operate from different assumptions.

In his book entitled "*The Pedi*", Monnig (1967) described in detail a diagnostic method used by some Sotho indigenous healers. Known as "sedimo", this method involves the use of a goat through which a patient's illness is established. The indigenous healer first applies some cleansing medicines on the goat's body. The patient will then be advised to blow his breath into the nostrils of the goat which will then be slaughtered. A postmortem operation is then performed on the goat by the indigenous healer who will examine the colour of the blood or any other peculiarities that may be noticed on the goat's organs. Any unusual conditions like a very dark blood colour and intestinal worms found in the goat will be presumed to be a reflection of a pathological condition in the patient's body. The rituals performed before the goat is slaughtered are perceived to transpose the patient's symptoms of disease to the animal. When the cause of the disease has been established and a cure prescribed, the meat is cooked with a view to "killing" the disease by fire before it is consumed (Monnig, 1967).

Gumede (1990) gives a description of a category of Zulu indigenous healers who do not use the conventional diagnostic methods like the divination bones. Known as "abalози", this category of indigenous healers is believed to have skills to interpret messages supposed to come from ancestors. On arrival at the indigenous healer's place, the consultees will be directed into a dark hut where the divination will take place. After all the necessary introductory remarks, the ancestor will "speak" with a faint whistle-like voice from the dome of the hut. The indigenous healer will interpret to the consultees what the ancestors are saying.

Whilst both indigenous healing and Western psychology (and psychiatry) make use of some diagnostic procedures to establish the cause and treatment programmes for the various conditions that their clients present with, the two systems differ in a significant way. For a

psychologist, a universal system (like the DSM IV or ICD 10) that is informed by clinical logic will form the basis for assessment and narrowing of diagnostic options. On the other hand, the diagnostic process for an indigenous healer could be seen as a more intuitive and spiritually inspired activity that is informed by local culture and knowledge systems. It is this influence of local traditions and practises that probably account for greater variations in the assessment systems of indigenous healers.

4.2.3. Therapeutic issues

A review of the literature indicates that indigenous healers use a number of methods in the treatment of their patients (Edwards, Cheetham & Mkhwanazi, 1983; Gumede, 1990; Karlson & Moloantoa, 1984; Schweitzer, 1980; Sodi, 1987). Though I will be focusing primarily on the treatment methods used by South African indigenous healers, examples from other parts of Africa will be given where appropriate. The aim in this section is to present the popular methods that have been fairly covered in the literature. These are herbal remedies, "vaccination", therapeutic dances, rituals and preventive methods.

(a). Herbal remedies: Vigorous attempts have been made both internationally and nationally to study the pharmacological properties of the herbs that are used by indigenous healers. This scientific venture is in response to the increasing claims about the positive medicinal properties of some of the indigenous herbs (Makhubu, 1978; Matthe, 1989; World Health Organization, 1977; 1978b). While a number of studies give pharmacological reasons for the success of herbal remedies, other studies have tended to attribute the popularity (and reported success) of indigenous herbs to their symbolic significance (Gumede, 1990; Ngubane, 1977). A case to illustrate this point is given by Sodi (1987) who describes one of the oral forms of medicines known as "segokgo". This is prepared by combining some barks, roots, twigs, and leaves of some trees or shrubs so as to make a small bundle which is then boiled and its juice administered to a patient. An indigenous healer interviewed in this particular study gave the following interpretation of "segokgo":

"['Segokgo'] means something that is bound together. By taking the herbs and making one bundle is like we are trying to collect all the diseases in your body into one thing. When

your sickness is in one place, the medicines will then penetrate into this area and cure the disease" (in Sodi, 1987, p.59).

Though it does appear from the above extract that indigenous healers do not have a sophisticated pharmacological theory if judged according to Western standards of medicine, one could argue that the indigenous healer's herbal preparations have a symbolic significance to the clients. It does however appear that detailed studies need to be done to investigate both the medicinal and psychological elements of the herbal preparations that are used by the indigenous healers in South Africa. Perhaps the initiative by the Medical Research Council (of South Africa) to set up a Research Group on Traditional Medicine (see Medical Research Council, 1997) will yield the much awaited results on the pharmacological properties of indigenous herbs.

(b). "Vaccination": Body contact as a therapeutic method is reported to be used by both the practitioners of indigenous and Western medicine in many parts of the world. One of the therapeutic methods that involve body contact is reported among the Sotho (Sodi, 1987) and Swazi (Makhubu, 1978) speaking people. Known as "go hlabela" in North Sotho, this practice of "vaccination" involves the use of a razor blade to make small cuts on the body surface of the patient. These cuts are deep enough to cause bleeding. Medication called "tshidi" (a powdered residue that is derived from burned herbs) is then rubbed onto the incised areas.

"Go hlabela" is believed to have both curative and preventive effects on the patient (Sodi, 1987). Though Makhubu (1978) identified similar clinical aspects in a study of indigenous healers in Swaziland, she warns of possible health risks that may be associated with this practice. For example, indigenous healers are often accused of using the same razor blade on many patients, and thus making the patient vulnerable to cross infection.

(c). Therapeutic dances: Two indigenous therapeutic dances that have received extensive coverage in the literature are "malopo" among the Sotho speaking people and "intlombe" (among the Xhosa speaking people). In this section I will only focus on the "malopo" experience since "intlombe" will be discussed when Buhrmann's Jungian interpretation of some aspects of

indigenous healing will be presented later in this chapter. Within the cultural framework of the North Sotho speaking people, "malopo" is seen as meaningful experience that suggests possession of a medium by ancestral spirits (Sodi, 1995). Boersema (1985) identified two broad categories of these ancestral spirits, namely, own or individualized spirits that have a direct (ancestral) relationship with the medium, and foreign / alien spirits which usually have their origins outside the tribe. According to Van der Hooft (1981) the "malopo" experience manifests itself as an illness whose symptoms commonly include "ancestor" dreams and psychiatric complaints like confusion, auditory hallucinations, disorientation and stuporous states. In order for this illness experience to be ameliorated, the possessed individual must perform the "malopo" dance. This dance is enacted within a group setting that involves the repeated beating of drums, song, clapping of hands, and rattling of calabashes.

Several studies have suggested that the "malopo" experience has some psychological significance to the experiencing individual. In a study that sought to compare the various categories of indigenous healers among the North Sotho speaking Bakgaga tribe, Olivier (1985) suggested that "malopo" has some resemblance to a hypnotic trance that results in a change in emotional expression and feelings of rejuvenation and hyper-suggestibility. Van der Hooft (1981) offered a Jungian explanation of the "malopo" experience by interpreting it as a way through which the possessed individual can actively make contact with the supra-personal (that is archetypal) layers of his psychic life.

(d). Rituals: A review of the literature shows that rituals among the indigenous populations of South Africa are performed for various reasons. For example, some of the rituals are performed: (i). at the life cycle stages of birth, initiation, marriage and death (Monnig, 1967; Ngubane, 1977); (ii). to thank the ancestors for successful accomplishment of a task (Hammond-Tooke, 1981; Buhrmann, 1984a); and (iii). when an illness strikes (Farrand, 1980; Farrand & Holdstock, 1982; Holdstock, 1980; Makwe, 1985). For the purpose of this study I will focus only on those rituals that are performed to bring good health.

A study done by Hammond-Tooke (1970) in the Ciskei (now forming part of the Eastern Cape Province) showed that, out of a sample of one hundred cases of misfortune in a rural area, seven percent of these were interpreted as caused by ancestors. The most logical question to ask is: Why should the ancestors who are regarded as the protectors also cause illness to strike their descendants? Hammond-Tooke gives three possible reasons for this apparent discrepancy. First, ancestor illness can be understood as a cautionary gentle nudging to remind people to perform certain prescribed rituals. Second, the illness could be an indication of ancestral wrath which comes as a result of gross negligence or commission of heinous offences by the living. Third, the ancestors may be making a call to one of their descendants to take up a call to become an indigenous healer. Whatever the explanation for ancestor illness, it does appear that certain rituals are performed in order to bring good health to individuals, members of a family, or even entire communities. A discussion of the possible psychological validity of these rituals will be given in another section of this chapter.

(e). Prevention: Staugard (1985) contends that prevention occupies a central role in the practice of an indigenous healer. In fact Staugard even went further to suggest that prevention is actually the single most common reason for a contact between a traditional healer and a client. Despite the significance of prevention in indigenous forms of healing, as suggested by Staugard and other authors (see Gumede, 1990; Hammond-Tooke, 1989; Sodi, 1987), this topic is not adequately covered in the literature. Instead much emphasis is placed on the treatment approaches, some of which have already been presented in the preceding pages. What now follows is an account of some of the preventive methods that are used by indigenous healers against witchcraft.

As previously pointed out elsewhere in this chapter, witchcraft is one of the popular causal explanations given for illness and misfortune among the indigenous South African people. It is therefore reasonable to expect people to take precautionary measures against the evil activities of those perceived as witches. According to Hammond-Tooke (1981), one of the common precautions is to avoid giving offence to neighbours lest they resort to professional sorcerers or magical charms to strike back. Gumede (1990) identified a number of preventive measures that the Zulu speaking people use to protect individuals and homesteads against

witchcraft and lightning. Apart from a protective tree called "intelezi" (Buffalo thorn), protective charms or medicines may be buried at the front door, at the gate, or entrance, or on the borders of the yard along the fence in order to bar witches.

Monnig (1967) makes mention of a preventive method that is used by the Sotho speaking people. A black powder called "tshidi" (already mentioned elsewhere in this chapter) is concocted with other preparations like ground seeds and fat of a goat and rubbed into a stick that is placed across the entrance to the hut of a sick person. According to Monnig, this activity is believed to serve two functions. First, the "tshidi" will protect the patient in his weakened state from being harmed by witches. Second, this protective measure acts as a visible warning to all people to discreetly enter the hut so as to avoid being inflicted with the same disease. This second function gives the impression that practitioners of indigenous healing are aware of the possible contagious effects of some of the categories of illness.

4.2.4. Categories of indigenous healers

The ethnic diversity of the indigenous people of South Africa has yielded many concepts that are used to refer to indigenous healers. Concepts like "ngaka", "igqira", "isangoma", "inyanga", "sedupe", "abalози" are thrown around to refer to one category or another of indigenous healer. To add to this long list of names, several English concepts like herbalist, diviner, medicine man, and even (the derogatory term) witchdoctor are used when reference is made to these practitioners of indigenous healing. Rather than add other names to the long list, this presentation will draw on the works of authors like Gumede (1990), Korber (1990), Kottler (1988), and Schweitzer (1980) who generally classify South African indigenous healers into four types, namely diagnosticians, healing doctors, specialists, and faith healers. Though I do mention and briefly cover faith healers in this section, it must be noted that within the broader context of this study, this group is not included.

(a). Diagnosticians: Known as "isangoma" (in Zulu), the diagnostician or diviner's primary function is diagnosis. Usually a female (Kottler, 1988, Ngubane, 1977), a diviner is charged with the responsibility to determine the cause of calamities, epidemics, and sickness that may from

time to time threaten individuals, families, and communities. For example, a diviner may be consulted to find out why cows are barren, why fields are not producing plenty of crops, why the young bride is not having a baby after two years of married life, why there is misfortune in one's family - in fact why anything has gone wrong (Gumede, 1990). Through what is believed to be spiritual contacts, the diviner will use techniques like bone throwing to arrive at a diagnosis of a problem.

After a diagnosis has been made, the diviner is supposed to refer the client to a healing doctor who will administer an appropriate treatment programme. Mkhwanazi (1989) does however point out that the majority of diviners are increasingly combining divination and treatment in order to acquire money. What Mkhwanazi seems to suggest is that the collapse of boundaries between diviners and healing doctors is motivated by economic factors.

(b). The healing doctors: This group of healers mainly practices the art of therapy or healing and is made up of medicine men or herbalists (Gumede, 1990). They have learned more about the use of herbs or medicines for healing purposes. In other words, the healing doctors have perfected their skills when it comes to the use of different types of medicinal roots, leaves, animal portions, minerals, fats, and other medical preparations. Gumede (1990) points out that among the Zulu speaking people, the art of healing is usually a male dominated activity which tends to run in families though not always. A practising herbalist will at some point usually identify one of his favoured sons who will then be guided through two stages in the process of becoming a herbalist.

During the first stage, which is known as apprenticeship, the trainee healer will usually accompany the healing doctor into the bush to collect herbs. It is during these errands that the novice learns about the medicinal values and pharmacological properties of the different herbs. During the second stage, the budding healing doctor takes on more responsibilities by going alone to collect herbs. At times he will be delegated to perform simple healing tasks on behalf of the healing doctor. When progress is satisfactory, the healing doctor will then allow the candidate to practice on his own.

While the diviner's practice is more general, it does seem that the healing doctor on the other hand is addressing specific health problems by prescribing medication after getting clients who will have been referred to him by the diviner. According to Gumedé (1990) the healing doctor, as compared to the other types of indigenous healers, is the one that could be likened to a general practitioner of Western medicine.

(c). Specialists: Just as there is a belief that there are people who know how to control lightning to injure, harm or destroy their enemies at will, there is an equal belief that there are people with special skills to stop lightning and to administer protective medicines to bar the activities of evil doers. Apart from these experts who can protect people against lightning, there are other specialist indigenous healers who have been identified in South Africa. These include traditional birth attendants (TBAs) or midwives, bone setters and rain makers (Gumedé, 1990; Hammond-Tooke, 1981; 1989; Monnig, 1967). In this presentation I will only touch briefly on traditional birth attendants who, in comparison to other specialist categories, seem to have received much coverage in the literature.

Several studies have indicated that traditional birth attendants offer a valuable service in terms of primary health care (Chipfakacha, 1994; Anderson and Frants, 1986; Nicholas & Voorhoeve, 1982). For example, some developing countries like Ghana, India, the Philippines, and Indonesia have, to varying degrees, tried to incorporate this category of health care providers in their national health care delivery systems (Neuman and Lauro, 1982). In fact the World Health Organization (1978b) has even proposed some guidelines that should be followed by countries that seek to officially utilize the services of traditional birth attendants. The issue about the utilization of traditional healers, including traditional birth attendants, will be fully debated in chapter eight of this study.

(d). Faith healers: Connected to the African Independent Churches, faith healers are a group of influential religious people belonging to a movement that represents a reformation of indigenous beliefs within a syncretic belief structure (Schweitzer, 1980). According to Miller (1984) and

Gumede (1990), this increasingly popular movement must be understood as a breakaway from the missionary Christian influence of the nineteenth century.

A number of explanations have been advanced for the rapid growth and attraction of the African Independent Churches. First, the missionaries who brought Christianity to Africa did not accommodate the traditional practices of indigenous people. Many traditional practices like those of indigenous healers were frowned upon, denigrated and dubbed superstitious and anti-Christian (Bodibe, 1992; Sodi, 1997; Zungu, 1992). Second, the authority status of faith healers who gain their authority through personal charisma tend to attract a lot of followers who come with the hope of getting help (Miller, 1984). A further reason may be that the African Independent Churches address themselves to the personal problems and conflicts that are brought about by rapid urbanization in South Africa (Miller, 1984; Schweitzer, 1980). The church in this regard is understood in terms of its integrative function which it provides to the alienated and socially insecure urbanized African. The suggestion here is that the influence of these African churches will increase as more and more African people are exposed to urbanization.

4.3. Psychological studies on indigenous healing

4.3.1. Buhrmann and a Jungian perspective on indigenous healing

(a). The African (Nguni) world view: In many of her writings, Buhrmann (1978; 1981; 1982b; 1984a; 1990) has consistently argued that there exists among the Nguni people of South Africa a layer of collective unconscious which she called the communal unconscious. This uniquely African way of being-in-the-world (understood to be shared by the indigenous healer and his patients) is shaped and determined by the norms and value systems of the Nguni culture. As she pointed out in her book entitled: *"Living in two worlds: Communication between a white healer and her black counterparts"*. Buhrmann (1984a) argues that Nguni people share certain internal and external experiences and events that are in a way uncommon to those of people in Western society.

As a way of supporting her argument, Buhrmann (1984a) identified three experiences that characterize the communal unconscious of the Nguni people. First, she suggested that Nguni people tend to emphasize the survival of the group and its healthy functioning. This orientation, in her view, would naturally lead to considerable interdependence within a family and community. By contrast, a tendency to be interdependent is seen not to exist in a Western world which is premised on the ideals and values of independence, autonomy, and individual ego development.

Second, Buhrmann (1984a) pointed out that, unlike in the Western world where human experience has been exceedingly fragmented and objectified, the Nguni people tend to have a holistic view that emphasizes cosmic relatedness and symbolic meaningfulness of natural and human phenomena. To illustrate her point, Buhrmann states that the Nguni people still attach a great deal of mythical and sacred significance to their natural surroundings. As she put it:

"... events in their [Nguni people] natural surroundings are usually still pregnant with some esoteric meaning. Western man has with his objectivity divorced himself from symbolic meaningfulness of these manifestations and has studied them scientifically, a tree or plant can have medicinal value but no mythical or symbolic influence" (Buhrmann, 1984a, p.85).

Third, Buhrmann (1984a) argued that ancestors play a central role in the understanding and subsequent interpretation and treatment of illness among the Nguni people. Seen as protectors who are omnipotent and omnipresent, the ancestors' participation in all the activities of the household are acknowledged. A symbiotic relationship is believed to exist between the living and their ancestors, the role of each being to keep the other happy and healthy. If angered, the ancestors are understood to have the capacity to withdraw their protection and thus expose an individual and his family or clan to evil powers of witches who can cause illness or misfortune.

While emphasizing the existence of a cultural layer of the collective unconscious that is largely African and thus inaccessible to a Westerner, Buhrmann (1977; 1979; 1983) however suggested that there are psychic similarities between Nguni people and their Western counterparts. The communal unconscious that she refers to is a component of the otherwise universal collective unconscious that to a Westerner would usually be experienced in the form of archetypal images that appear in dreams, visions, fantasies, and creative activities. What Buhrmann is suggesting is that the Nguni people, like their Western counterparts, do have the collective unconscious. What is however different is the nature of the archetypal images that constitute the content of the collective unconscious of each of the two groups.

(b). The "thwasa" experience (becoming an indigenous healer): According to Buhrmann (1982a), a person called to become an indigenous healer will initially complain of strange dreams and some emotional disturbances like restlessness, irritability, violence, aggression, and social withdrawal. When such experiences are noticed, the affected individual will usually be taken by his family to an indigenous healer who will provide a diagnosis for the problem. Treatment that will result from such a diagnostic activity will consist of (i). milieu therapy by which the patient will be incorporated into the household of the indigenous healer, (ii). medication for sedation, purification, and "opening of the trainee's mind" to ancestral messages, (iii). dream interpretation, and (iv). ritual dancing sessions and ritual ceremonies which may or may not involve the sacrifice of animals. Upon completion of the treatment and apprenticeship programme, the graduate will be taken home to a cheerful ceremonial welcome by his family.

In a number of her writings, Buhrmann (1981; 1982a; 1983; 1984a; 1984b), has sought to demonstrate that the "thwasa" experience is not pathological if understood from a Jungian perspective. The ancestors who are believed to enter into dialogue with a "thwasa" person, are interpreted by Buhrmann (1990) as personifications of unconscious psychic complexes. As already pointed out in the previous section, these unconscious complexes are a manifestation of the communal unconscious which, in Buhrmann's view, characterize the Nguni people.

Throughout the process of apprenticeship, the budding indigenous healer would be sensitized to relate to and to accept ancestral and other archetypal images and fantasies that come from the unconscious part of the psyche (Buhrmann, 1989; 1990). In so doing, Buhrmann argues, the "thwasa" person will learn to accept, trust, respect, and understand his psychic phenomena - a kind of psychic exploration that is necessary to reduce the negative power of unconscious factors:

"[This psychic exploration of the unconscious] ... is necessary to reduce the negative power of these (unconscious forces) and thus increase the positive and healing forces, i.e. releasing the individual from the rule of unconscious complexes and their daemonic power. In this way, an easy relationship between the ego and the largely unknown but rich and creative unconscious can be established" (Buhrmann, 1979, p.21).

What Buhrmann is trying to suggest in the above extract is that the process of "thwasa" would help the affected person to harmonize the relationship between the ego and what would previously have been experienced as unpleasant and fearful unconscious forces. Through the "thwasa" experience, the general attitude of fear and distrust of the unconscious part of the psyche is thus replaced by the one of acceptance, trust and respect of the contents of the collective unconscious.

(c). Myths, rituals and, ceremonies: Over a period of many years during which she studied the experiences of the Xhosa speaking people of the Eastern Cape, Buhrmann and her colleagues (see Buhrmann, 1981; Buhrmann, Nqaba & Gqomfa, 1981; 1982) identified a number of rituals and ceremonies that this community observes. Among others, these authors identified rituals like "xentsha", "isiko lentambo" and various kinds of river ceremonies. Performed at different stages in people's lives, these rituals are understood by the Xhosa people to be a way of communication with and relating to the ancestors.

Drawing from the work of an existential analyst by the name of Rollo May, Buhrmann (1990) argued that the ritual ceremonies are a way of acting out or externalizing myths. By acting out the myths (seen as clusters of symbols), the individual together with the other members of the community participating in the ritual, get in touch with the unconscious layers of their

psychic lives. Buhrmann (1990) further argued that, apart from lowering the individual's anxiety, these rituals reintegrate the affected person with the community, thus avoiding isolation which is seen as a source of hopelessness and helplessness.

What I will do now is to select and closely look at "intlombe" ritual and try to illustrate how Buhrmann has sought to explain and interpret this experience from a Jungian perspective. "Intlombe" is a dance ritual that forms an integral part of all healing and "thwasa" activities performed by Xhosa indigenous healers (Buhrmann, 1981; Buhrmann, Nqaba & Gqomfa, 1981; 1982). Whilst the complexity of these rituals will vary depending on the circumstances under which they are performed, the structure thereof is more or less the same. Buhrmann (1981) identified four concentric circles which she postulated to characterize the "intlombe" ritual. The first circle, which happens to be the largest, consists of the walls of the hut wherein the "intlombe" ritual is performed. The second circle is formed by the singing and hand clapping participants, with the males on the right and females on the left. This group of participants will usually be members of the family, friends, and visitors. The third circle consists of the dancing group, usually moving in an anti-clockwise direction. The fourth and most inner circle consists of the fireplace.

The structure as described above is according to Buhrmann (1981) typical of the universal mandala with the outside circles (the walls of the hut) symbolizing the *tremenos* - the precinct of the temple. The concentric circles envelope a centre which reflects a high concentration of libido or psychic energy. Such energy has the power to bind potentially disintegrative and disruptive forces such as opposites (for example, the males and females in the second circle) together and to permit reintegration or birth of new attitudes, new insights, or new aspects of personality. With the dance and singing, more introversion of psychic energy is induced:

"Attention and libido is withdrawn from external events and objects and turned towards the inner life and inner events. The chief participants occupy themselves intensely with their 'illness' - they talk about it, sing about it, praise it and invoke the help of ancestors, especially to strengthen the powers of their healers to enable them to cope with the illness" (Buhrmann, 1981, p.25).

In addition to the ability to induce introversion of psychic energy, the rhythm and stamping movements of the "intlombe" dance has a penetrating quality of phallic magnitude. As Jung (cited in Buhrmann, 1981) has stated:

"The fast and treading movements are invested with phallic significance or with that of re-entry into the womb, so that the rhythm of the dance transports the dancer into an unconscious state" (p.197).

Apart from the dance itself, the songs are symbolically meaningful as their content will touch on family tensions, ill health, problems about relationships, misfortune, and obscure dreams (Buhrmann, 1981). In other words, the songs will help the affected individual to access and, in a less threatening environment, deal with the unconscious psychic conflicts.

(d). The use of dreams: In her research work through which she attempted to understand the dreams of one indigenous healer and his trainees, Buhrmann (1978, 1984b; 1990), consistently drew parallels between the role of dreams in Xhosa indigenous healing and Jungian psychology. As in the case of myths and rituals, dreams were explained by Jung (1917; 1963) as contents of both the personal and collective unconscious. For Buhrmann (1984a) however, the indigenous healer's dreams come from the collective or communal unconscious.

Buhrmann (1984a) contended that by actively being involved with his dreams, the indigenous healer is in a position to access the hidden and culturally meaningful layers of his own psyche and that of others. Similarly, his clients who will also be encouraged to actively relate to their own dreams, are given the opportunity to access these archaic layers of experience as well. Dreams thus become a way for the collective unconscious layers of the healer and the client to interact in a much meaningful way and thus bring about positive therapeutic change. Buhrmann's Jungian analysis of the experiences of indigenous healers has been critically reviewed by several authors. I will now present these critical reviews which point to both the strengths and weaknesses in Buhrmann's view.

(e). A critique of Buhrmann's work - the strengths: In an article entitled "Vera Buhrmann's approach to cultural psychiatry", Schoeman (1985) presented a positive picture of Buhrmann's work which he described as "... a cautious guide ... into the depths of African cosmology" (p.7). Schoeman particularly appreciated what he sees as Buhrmann's incisive analysis of Xhosa rituals and ceremonies which, from a Jungian perspective, are interpreted as reflections of the cultural layer of the collective unconscious. In his article, Schoeman identified three main contributions that Buhrmann made to the field of cultural psychology. First, he commends Buhrmann for developing and applying a practical research approach which could serve as a guideline for researchers who would like to work in the fields of cross cultural psychology and psychiatry. The practical research approach that Schoeman refers to is the participant observation method that Buhrmann applied to study one indigenous healer for many years. The difficulties with this research approach as adopted by Buhrmann, are however highlighted later in this chapter. Second, Buhrmann's tendency to describe the meaning of illness from the perspective of the Nguni people is seen by Schoeman (1985) as a significant contribution that could be emulated. Thirdly, Schoeman is of the view that Buhrmann's work lays a foundation for future development of diagnostic and therapeutic approaches which would be sensitive to the African (Nguni) experiences. Schoeman's sentiment was earlier expressed by Sandner (1982) who, in his analysis of Buhrmann's work, concluded that there were some striking similarities between Xhosa and Navaho methods of diagnosis and treatment. Apart from the appreciative comments by Schoeman, Buhrmann could also be commended for her boldness to venture into a field that was long avoided by mental health professionals.

(f). A critique of Buhrmann's work - the weaknesses: Whilst Buhrmann's contributions are evident, there are a number of weaknesses that can be identified in her work. First, the very theoretical basis (the Jungian approach) of her work has not only been challenged on empirical grounds, but also for being silent on broader sociopolitical and economic issues (Roper, 1992). By failing to acknowledge realities like racism, Roper argues, Buhrmann stands the risk of providing a narrow and distorted understanding of the African experience which she has so much devoted her life in trying to explicate.

Second, Buhrmann has been criticized for adopting a research approach that is subjective and reliant on the experiences of one indigenous healer and his trainees. This subjective approach:

"... coupled with her reliance on Jungian archetypal theory with its many intricacies and obscurities makes assessment of reliability of her research difficult. Buhrmann's findings are, as she admits, very much a product of her own approach and it is unclear the extent to which another researcher would have reached the same conclusions" (Roper, 1992, p.55).

Whilst Roper's point may be valid, Buhrmann however has consistently made it clear in her writings that she never intended to generalize her findings to a much larger population. As she put it: "I must re-emphasize the fact that I am researching a particular group of indigenous healers. At the moment I have no means of assessing how representative they are" (Buhrmann, 1982b, p.179). Later in another contribution, Buhrmann (1984a, p.14) echoed the same sentiment:

"I must add that one usually perceives what one has been trained to see and what fits in or is compatible with one's psychological make up. Pure objectivity is a myth, especially in the human sciences, and I cannot exclude, nor do I apologise for, a measure of subjectivity which is inevitable" (p.14).

Third, Buhrmann has been criticized for providing a romantic and idealist view of African (Nguni) culture (Swartz, 1985; 1986; 1987; 1991). The tendency within this view is to devalue Western culture which, according to Buhrmann (1990), has so much fragmented that its symbols have collapsed. In contrast, Xhosa culture is seen as integrated. Xhosa people are understood to "have a cosmic relatedness where *everything* (own italics) has a meaningful place" (p.333). It is this cosmic relatedness that makes the philosophy of the Nguni people to be more holistic and closely related to nature - attributes that, according to Buhrmann, are missing in the Western culture. According to Swartz and Foster (1984), the problem with this idealized view is that it tends to communicate two problematic assumptions. First, Westerners and traditional African people are seen to live in two different worlds, and second, the evolutionary passage between the two worlds (that is African and Western) inevitably leads to the loss of holism, security, and an integrated universe.

4.3.2. Schweitzer's phenomenological studies on indigenous healing

(a). The "thwasa" experience: In his dissertation for a Masters degree, Schweitzer (1977) sought to understand three categories of experience amongst the Xhosa speaking people of South Africa. One such experience that he studied is the "thwasa" experience which, as already indicated elsewhere in this chapter, is a process through which an individual becomes an indigenous healer. Schweitzer's major objective in the dissertation was to uncover the nature and meaning of the "thwasa" phenomenon. Approaching the subject from a phenomenological perspective, Schweitzer (1977) described the "thwasa" phenomenon as a creative experience through which the affected individual:

- (i). is helped by an indigenous healer, clan members, and the whole community to interpret his symptoms within an African (Xhosa) cosmology,
- (ii). establishes positive contacts with the spiritual world, and
- (iii). acquires respect and wisdom in his community by virtue of the new role as an "igqira" (indigenous healer).

Following from his dissertation, Schweitzer collaborated with Buhrmann to write a journal article on the "thwasa" experience. Extending on the phenomenological interpretation, Schweitzer and Buhrmann (1978) viewed the "thwasa" experience as "a process of disintegration, resulting in chaos, which then enables reintegration to occur" (p.15). Concluding the article, these two authors went on to suggest that the "thwasa" phenomenon be seen as a meaningful experience that is purposefully directed towards altering and determining the individual's new role in society. Schweitzer's views and those he jointly expressed with Buhrmann contrasted the predominant notion which portrayed the "thwasa" experience as disintegrative. For example, as early as 1937, Laubscher described the "thwasa" experience as a schizophrenic process. Since he held the view that schizophrenia is an inherited biochemical disorder, he treated the finding that indigenous healers have ancestors who are also indigenous healers as a confirmation of a psychopathological process that runs in the family (Laubscher, 1937). A similar view was also expressed (albeit mildly) by Lee (1969) who described the "thwasa" experience as a psychoneurotic condition.

(b). The role of dreams: Schweitzer's findings about the "thwasa" experience and other categories of experience prompted him to again adopt a phenomenological approach in order to study dreams among the Xhosa speaking people - the same population from which he had drawn a sample for his previous study. In this particular study, Schweitzer (1980) sought to understand the meaning of dreams from within the context of the Xhosa culture. His main aim in the study was to explicate the interpretation of dreams by two groups of people he referred to as dream experts. The first group comprised of indigenous healers drawn from a rural area whilst the second group comprised of "prophets" and members of the African Independent Churches. The second specific aim of Schweitzer's study was to examine the commonalities and differences between the interpretation of dreams by these two groups.

Essentially Schweitzer found striking similarities in the way the two groups of dream experts interpreted their dream experiences. Both groups expressed a notion of cosmic relatedness that is facilitated by these dream experiences. This cosmic relatedness, Schweitzer continued, was found to include a numinous dimension which is expressed through divine presence in the form of ancestors, holy spirits, or God. The divinity that characterize these two groups' mode of being-in-the-world was found to be revealed in their daily lives and healing activities.

In another study that was prompted by the results of his thesis, Schweitzer (1983) did a phenomenological analysis of indigenous healing by focusing on the role of dreams and dance as well as the diagnostic sessions (known in Xhosa as "vumisa") in the practice of an indigenous healer. In the case of dreams, Schweitzer gave an illustration of their significance by presenting case material about one indigenous healer whose activities he observed for over six years. The important highlights from this case study could be summarized as follows:

- (i). Dreams enable the dreamer to relate intimately to his deceased parents who in the context of Xhosa cosmology are not dead but have passed on to become ancestors. By relating to his dream material in this way, the individual and ancestors become mutually accessible to each other in ordinary experience,
- (ii). Consequently, this interpretation of the dream material would help the individual to avoid

isolation and to live in relation to other beings.

(c). Diagnosis and treatment in indigenous healing: In the majority of cases the Schweitzer (1980) has observed, the patient together with his family will visit an indigenous healer with the purpose of a consultation. During the session, the indigenous healer will communicate his clinical impressions to the consultees and also give a formulation of the reasons and dynamics underlying the problem. The indigenous healers that Schweitzer had dealings with tended to explain their capacity to diagnose in terms of their ability to communicate with the ancestors during the "vumisa" session. As one of the indigenous healers described the "vumisa" process:

"I know it this way; nobody tells me in my ears but I know it in my blood. This is the 'disease' of the igqira [indigenous healer] which is in me ..." (in Schweitzer, 1980, p.278).

Whilst the diagnostic approach as described above gives a suggestion that indigenous healers make use of an extra-sensory mode of perception (a suggestion that is difficult to validate), Schweitzer is of the view that the "vumisa" session is of psychological significance. He interprets the indigenous healer's divination procedures as a means to transform an experience of discomfort (sickness) into a meaningful and understandable event. In other words, what is initially experienced as chaotic is interpreted within the patient's culture in terms of its personal and social significance.

Having made a diagnosis, the indigenous healer will put together a therapeutic programme that may include the use of herbs, milieu therapy, and particular forms of dancing and singing (Schweitzer, 1985). Through his diagnostic sessions and the various modes of treatment, the indigenous healer is understood to restore the client's sense of control over life processes, thus enabling him to respond creatively to existential fluctuations and change. The indigenous healer is, within the context of the Xhosa culture, seen to respond to the patient's needs for structure and to clarify his (the patient's) belief system and values.

4.3.3. A comparison of indigenous healers and Western trained psychologists: Edwards' clinical studies

(a). A comparison of interview methods: In an attempt to compare indigenous healers and Western psychologists, Edwards (1986) in conjunction with his co-workers conducted an investigation on three patients who were drawn from Ngwelezane Hospital in the KwaZulu Natal Province. In this study, the specific aim was to compare the interview methods and treatment plans of three categories of indigenous healers and three Western clinical psychologists in an initial interview with the same patients. Each of the six therapists was given three quarters of an hour to conduct an initial interview with each of the three patients. After these interviews, the researchers administered a standard questionnaire to the therapists in order to record their impressions. The patients were also asked to rank the six therapists in terms of their helpfulness. The investigation lent support to the observations often made in the literature (see De Villiers, 1985; Edwards, Jainairan, Randeree & Rzakowolski, 1982; O'Connel, 1980; Ngubane, 1977) concerning the broad natural and supernatural explanations that indigenous healers advance to explain their patients' problems. Specifically, Edwards' study found that indigenous healers and Western psychologists differed in their causal explanations of the patient's problems. Despite the differences in terms of causal interpretations, the study found that there was a significant level of agreement between the indigenous healers and psychologists concerning diagnosis and treatment of the same patients. In terms of perceptions, both indigenous healers and psychologists were favourably rated as being more or less equally helpful by the patients studied.

Whilst Edwards' study has got considerable methodological shortcomings, given the sample size, it does however offer challenging thoughts on the two forms of healing. The fact that he has in fact brought the indigenous healers and the psychologists together under one roof to look at the same patients is a pioneering and commendable step. Also the fact that indigenous healers tended to agree more among themselves in terms of diagnosis and treatment (compared to the relatively low level of agreement among psychologists) may suggest that this category of health care providers are more consistent in their approach than is currently believed. Another positive element about this study is that Edwards has used primary sources in the form of interviews and actual recordings of research proceedings. These primary sources thus provided

this researcher with fairly rich data to form the basis for analysis,

(b). A case study - treatment of "umeqo": In another study aimed at comparing indigenous and Western healing methods, Edwards, Cheetham, and Mkhwanazi (1983) sought to investigate how the treatment of "umeqo" (already explained in an earlier section of this chapter) could be handled by indigenous healers and their Western counterparts. In this regard, Edwards et al provided a case study of a 29 year old Zulu woman whose complaints included terrific pains in her left leg and left arm. Following these complaints, the lady was reported to have lost function of her left side of the body. From a Western psychological perspective, this particular case was diagnosed as conversion hysteria which was indicative of an underlying interpersonal conflict that the patient was struggling with. As treatment, Edwards et al prescribed hypnotherapy which showed positive results after three months. "Success" in this case was attributed to a good therapeutic relationship, the therapist's understanding of the cultural dynamics involved, and offering therapy in the patient's own language.

The same patient mentioned above later consulted an indigenous healer who also suggested the cause of the problem to be an underlying interpersonal conflict. In this instance, the conflict was interpreted to be caused by jealousy and sorcery which was linked to the third wife of the patient's brother. The indigenous healer prescribed an intervention programme that comprised of rituals intended to purify the homestead. In concluding their study, Edwards et al pointed out that whilst the Western trained psychologists and indigenous healers attributed the illness of the patient under investigation to an underlying interpersonal conflict, these two groups of healers differed in terms of the explanations on how the problem came about and also how it should be treated. For example, whilst the indigenous healer prescribed a ritual, which necessarily involved the participation of other family members in the treatment, the Western oriented psychologist preferred an individual centred form of therapy.

Whilst raising a few interesting points, the above study by Edwards et al is beset with a few limitations that challenge the validity of the conclusions made. First, it is not clear whether Edwards et al are making a suggestion that "umeqo" (as understood and interpreted by a Zulu

indigenous healer) is the same as conversion hysteria (as understood and interpreted by Western psychology and psychiatry). Secondly, the study does not clearly indicate to us the extent to which the "success" of their case could be attributable to hypnotherapy and what percentage to what they call cultural counselling. Third, the use of one case study does not provide sufficient data upon which to draw such parallels between Western and indigenous forms of healing.

4.3.4. Client-centred and experiential perspectives on indigenous healing

(a). A review of Mkhize's comparative study: In her Masters dissertation, Mkhize (1981), tried to draw parallels between indigenous healing systems and two Western therapies, namely Rogers' (1951) client centred and Gendlin's (1962) experiential psychotherapies. In the case of client centred psychotherapy, Mkhize identified and analyzed Rogers' (1957) three necessary therapist characteristics of warmth, empathy, and genuineness. Even though she does acknowledge the different philosophical underpinnings of the two healing systems, Mkhize is of the opinion that indigenous healers tend to have these Rogerian therapeutic attributes.

One example she gave to substantiate her argument was that of a Rogerian therapist who is expected to be genuine in his dealings with a client. Such genuineness on the part of the therapist has been found to facilitate self understanding and positive change on the part of the client. Mkhize suggested that such genuineness does also exist in the case of indigenous healing. Mkhize (1981) gave the following description of the experience of a trainee indigenous healer to illustrate her point:

"It might be interesting to view unconditional positive regard in relation to what happens during divination sessions whereby as the novice verbalizes all her formerly unaccepted and denied feelings she receives the confirmation of genuine understanding from the chief diviner and the unconditional positive acceptance of what she is becoming" (p.117).

Mkhize's attempts to draw parallels between indigenous healing and Rogers' client centred therapy were later emulated by Mkhwanazi (1985) whose views will be a subject of analysis in another section of this chapter.

In the case of a comparison between indigenous healing and Gendlin's experiential therapy, Mkhize (1981) advanced her views by first giving a background description of this therapeutic approach. Central to experiential therapy is the notion that patients must be provided with conditions that facilitate experiencing of feelings. The point raised by Gendlin (1962) is that people often talk about their feelings of anxiety, anger, fear, etc in a therapeutic situation without really getting to the experiential level of these emotional experiences. Through a technique of focusing, Gendlin allows the client in therapy to experience feelings in all their complexities.

Mkhize is of the opinion that indigenous healing parallels this form of Western psychotherapy. To substantiate this claim, she gives an example of the divination process and its experiential significance to the client. By leading the client for more than an hour through a diagnostic process of establishing the cause of an illness and developing an appropriate treatment plan, the indigenous healer, Mkhize argues, provides the optimum conditions that facilitate focusing and experiencing on the part of the client. I will once again quote Mkhize (1981) at this point to illustrate the point she is trying to make:

"During this critical moment [of divination] the diviner and her patient do not even look at each other but each has to look down and try to forget about the surroundings and only concentrate on the bodily felt experiences" (p.119).

Though Mkhize's comparative analysis of indigenous healing and some Western psychotherapies is commendable for raising an interesting debate, her study appears to have some methodological limitations which, by her own admission, may have affected the findings. As she candidly admits in the conclusion of her dissertation:

"... it is essential to emphasize that other people would find it difficult to understand or to accept some parallels which have been drawn between experiential psychotherapies and indigenous healing. This difficulty might be partly due to the fact that I have compared a well developed Western theory and methodology with the cultural experiences which have not been formulated in theoretical constructs" (Mkhize, 1981, p.128).

It is interesting to note that in her subsequent research activities, Mkhize has stayed clear from this contentious topic of comparing two healing methods which have different epistemological foundation. For example, in her paper entitled : "Psychotherapy in a university setting - a clinical psychological case report", Mkhize (1985) investigated the psychological problems experienced by adolescent students at a black university and concluded that both transactional analysis and Gestalt therapy approaches are well suited to help this category of students to overcome developmental and identity stresses. Another weakness in Mkhize's work has to do with her use of secondary sources in her investigation. Her study is not based on her own "field work". Instead she analyzed records gleaned from sociological and anthropological investigations to develop her ideas.

(b). Therapeutic methods of indigenous healers - Mkhwanazi's study: Following in the footsteps of Mkhize (discussed above) and concentrating on Zulu speaking indigenous healers in the KwaZulu Natal Province, Mkhwanazi (1986) sought to investigate this category of health care providers' therapeutic methods. The main aim of her study was to investigate if the therapeutic conditions of empathy, warmth, and genuineness as propagated by Truax (1963) and Truax and Carkhuff (1967) are present in the relationship between the indigenous healer and her clients. Once this was established, the researcher would then seek to draw parallels between the therapeutic methods of indigenous healers and those of Western trained therapists.

Five psychiatric patients from King Edward VIII Hospital and five indigenous healers were selected and invited to the Department of Psychiatry at the University of Natal Medical School. The interviews between the indigenous healers and the patients were videotaped and rated by four clinical psychologists. These psychologists rated brief segments of the tapes using Truax and Carkhuff's (1967) five point scales of empathy, warmth, and genuineness. Extrapolating from the results of the ratings, Mkhwanazi concluded, though cautiously, that the three conditions of empathy, warmth, and genuineness are present in varying degrees in the therapeutic practice of indigenous healers. On the basis of these findings, Mkhwanazi went on to argue that indigenous healers, like Western trained therapists, have skills to bring improvement on the part of their patients.

By her own admission, Mkhwanazi's study has got a number of methodological limitations. For example, her findings were based on the ratings by psychologists of brief segments of various videotaped sessions that involved indigenous healers and patients. It is my view that such ratings based on brief segments of taped interviews would not be sufficient to be generalized to whole sessions. The second problem with Mkhwanazi's study relates to issues of therapeutic outcomes. Apart from having to contend with Eysenck's (1952) reservations about the effectiveness of psychotherapy, the reported success of the five therapy cases was based on verbal reports from the clients and their relatives. Such subjective verbal reports thus bring into question the validity of the conclusions made. The third weakness in Mkhwanazi's study is the criterion used in the choice of indigenous healers who served as subjects. As she pointed out: "The diviners were selected in terms of popularity. It was thought that the more popular they are the less the chance there is of their being charlatans" (Mkhwanazi, 1986, p.75). It is doubtful whether a subjective construct like popularity was a sufficient criterion for the selection of the indigenous healers who participated in the study. Another limitation of her study is a rather philosophical problem of having to judge one therapeutic system on the basis of standards that are developed from within a fundamentally different epistemological framework. Despite the major shortcomings raised above, Mkhwanazi's investigation can be commended for encouraging debate by comparing two fundamentally different healing systems.

4.4. Concluding remarks

The two main aims of this chapter were (i). to review some cultural studies on indigenous healing, and (ii). to discuss some psychological studies that have been done in South Africa to understand indigenous healing. From the literature reviewed in this chapter, it becomes clear that there is, in South Africa (like in other parts of the world) a coherent cultural theory that individuals and communities employ in rendering their unpleasant experiences meaningful. In addition, there are certain individuals (i.e. indigenous healers) within this cultural system who are perceived to have the appropriate skills to can treat these culturally constructed illness experiences. The psychological studies that have been reviewed in this chapter generally give a suggestion that there are certain therapeutic skills and approaches that indigenous healing share with some Western therapeutic methods.

CHAPTER 5

METHOD OF INVESTIGATION

5.1. Introduction

In the first section of this chapter, I will give a review of the qualitative approach on which the present study is premised. I will start by giving a brief overview of the philosophical debate between the adherents of quantitative methods and those in support of qualitative methods. This will be followed by a discussion of the intellectual history of the qualitative approach. Finally, the section will be concluded by a presentation of three major characteristics which constitute the basis for qualitative researchers' claim for a scientific status. In the second part of the chapter, I will specifically focus on phenomenology as one of the qualitative approaches. The works of Edmund Husserl and Amedeo Giorgi will be reviewed in view of their contributions to phenomenology as a theoretical and research approach. The third and final section of the chapter could be seen as more technical in the sense that I will give an account of the phenomenological method of inquiry as used in the present study. The procedures that have been followed in data collection and analysis will be elucidated.

5.2. The philosophy of qualitative research

5.2.1. Quantitative versus qualitative approaches

Various studies have suggested the following five principles as the foundational premises on which the quantitative and qualitative research traditions differ (Bryman, 1993; Edwards & Potter, 1992; Mouton & Marais, 1991; Myburgh & Poggenpoel, 1995; Parker, 1992).

a). Hypothesis testing versus theory generation: Unlike a qualitative researcher who will usually subscribe to the holistic notion that regards human experiences and social phenomena as entities to be explicated and understood in their entirety, a quantitative researcher on the other hand seeks to break down the social world into manageable packages like racial prejudice, religiosity, aggression, and so on. These packages are identified and demarcated as problem areas which are then transformed into research hypotheses which postulate causal relationships between two or more variables in one or more populations (Bryman, 1993; Mouton, 1988; Mouton & Marais, 1991; Retief, 1988).

The quest to establish causal relationships was eloquently expressed by Babbie (1979) when he made the following observation:

"One of the chief goals of a scientist, social science or other, is to explain why things are the way they are. Typically we do that by specifying the causes for the way things are: some things are caused by others" (p.243).

The above quotation indicates that Babbie and his colleagues in the quantitative research tradition will be primarily concerned with establishing causal relationships between phenomena. This kind of research orientation thus calls for the formulation of hypotheses before an investigation is embarked upon. They will also ensure that these hypotheses are formulated in such a manner that they may be rejected or confirmed. In other words, the whole investigation will primarily revolve around an hypothesis.

On the other hand, qualitative researchers tend to provide no more than a general research aim in their introductions (Mouton & Marais, 1991). By going into the research field with no preconceived theoretical frameworks, the qualitative researcher could thus be seen to be more inclined towards theory generation. In other words, qualitative researchers favour an approach in which the formulation and testing of theories and hypotheses proceed in tandem with data collection.

b). Observation: Positivism in the social sciences maintains that only observable or measurable aspects of human behaviour are supposed to be the subject matter of the social sciences (Bryman, 1993). What is implied here is that people's subjective experiences (like faith, underlying motives and hidden intentions) are not supposed to be accommodated as valuable material from which scientific knowledge may be derived. The anti-positivists on the other hand, will strongly dispute this claim and instead regard the myriad and often subjective nature of human experience as the basis for a true and rigorous social science (De Koning, 1986; Prilleltensky & Fox, 1997). Instead of controlling the context and only focusing on observable variables, as quantitative researchers will try to do, qualitative researchers take the broader context of the investigation into account and become involved with the phenomenon under investigation (Giorgi, 1992; Kvale, 1983; 1994; Van der Burgh, 1988). In so doing, unexpected events are recorded and interpreted as the

researcher goes about generating a theory or hypothesis.

c). Method of inquiry: In line with the emphasis placed on the study of observable aspects of human behaviour, the adherents of the quantitative approach are of the view that the subject matter of the social sciences should be understood through the same scientific methods of the natural sciences (Von Wright, 1971). In terms of this principle, which Giedymin (1975) calls methodological monism or naturalism, social sciences should use the same procedures and methods of investigation that a natural scientist would, for instance, follow when studying molecules or atoms.

As it would be expected, qualitative researchers call for the adoption of what they regard as appropriate research strategies that are useful to social phenomena. In this regard, various methods like participant observation (Schurink & Schurink, 1988; Spradley, 1980; Van der Burgh, 1988), phenomenology (Giorgi, 1970a; 1970b; 1975; 1985a; 1985b; 1994; Husserl, 1977), and discourse analysis (Burman, 1996; Burman, Kottler, Levett & Parker, 1997; Burman & Parker, 1993; Edwards & Potter, 1992; Parker, 1992) have been developed over the years.

d). Generalization: It is common to look at the quantitative and qualitative dichotomy in terms of nomothetic and idiographic modes of research (Bryman, 1993). Quantitative research is usually taken to reflect the nomothetic model which is concerned with generalization of research results beyond the confines of the research location. In order for the results to be legitimately generalized to a wider population, quantitative researchers would tend to pay a great deal of attention to representativity of samples. On the other hand, qualitative researchers frequently conduct research which does not aim at generalizability, but rather careful description or hypothesis generation (Mouton & Marais, 1991).

e). The question of values: Positivists will usually insist on purging the social and political influences out of the social sciences with the hope that scientific can become objective and value free. Qualitative researchers on the other hand tend to argue that, by its very nature, social science is premised on social and political values prevailing in a particular society (Banister, Burman,

Parker, Taylor & Tindall, 1994; Henwood & Nicolson, 1995). As Huysamen (1994) points out:

"While the natural scientist has nothing in common with his / her research objects (plants, gases, minerals etc.), the social and behavioral scientist is in reality a member of what is being studied" (p. 166).

What Huysamen is trying to say here is that social scientists can not detach themselves from the cultural and sociopolitical environment within which these investigations are carried out. In other words, qualitative researchers would tend to acknowledge the influence of values in the products of their investigations.

5.2.2. The intellectual underpinnings of qualitative research

Emerging largely as a reaction against the domination of positivism in the social sciences, qualitative researchers adopted philosophical positions that provided the basis for qualitative methods in the social and behavioural sciences (Mouton, 1996; Patton, 1990). The strongest influence on this emerging breed of social science researchers came from phenomenology which will be discussed in the next section of this chapter.

Another strong influence on the qualitative approach is traced to the philosophical view of naturalism which should not be confused with methodological naturalism of the positivist tradition (Bryman, 1993). Naturalism as used in the anti-positivist sense, calls for the study of phenomena in their natural settings. In other words, the qualitative researcher should display the same fidelity to the human experience in the same manner as a botanist studies flora and fauna. As Bryman (1993) aptly put it:

"Naturalism, in this (anti-positivist) sense, departs from the practices of quantitative researchers, who are depicted as imposing their own conceptual schemes on the social world and using research instruments (e.g. experiments, survey interviews) which interrupt or disturb the naturalness of that world" (p. 58).

Other intellectual precursors of the qualitative approach include George Herbert Mead's symbolic interactionism, Max Weber's idea of 'verstehen', and Harre's ethogenics (Bryman, 1993). All these five intellectual traditions are believed to have shaped the nature of the qualitative research approach as it stands today. The characteristics of this research tradition which will be the focus of the discussion that will now follow reflect, to varying degrees, these intellectual undercurrents.

5.2.3. Major characteristics of qualitative research

A closer look at the literature suggests that the various qualities of qualitative approach can be collapsed into three major characteristics that essentially constitute the basis for qualitative research's claim for a place in the world of scientific inquiry.

Firstly, qualitative researchers generally tend to have a strong commitment to seeing through the eyes of those being studied. According to Hedegaard and Hakkarainen (1986), such a commitment calls for a considerable level of involvement with the people whose experiences the researcher is trying to investigate. The suggestion here is that the researcher should be involved by becoming part of the subject's life situation for some time. This point was better illustrated by Elkonin (in Hedegaard & Hakkarainen, 1986, p.141) who gave an example of an investigator who studies the inner relations of children's play by becoming part of it even if he / she participates minimally. Though such involvement in his / her subject's activities is advisable in the context of qualitative research, two possible dangers appear to make this difficult. The first difficulty lies in the possibility of the researcher becoming too involved with the subjects to such an extent that he / she may fail to adequately address the research goals. On the other hand, a researcher expected to be actively involved with the subject may find this arrangement uncomfortable and thus tend to revert to an 'objective' distant relationship.

The second major characteristic of qualitative research is that the process of investigation tends to produce detailed or thick descriptions of the social phenomenon under investigation. According to Bryman (1993) and De Koning (1986), such descriptions help the researcher to understand what is going on in a particular context and to provide pointers to other layers of

reality. Such contextual information about the subject is hardly obtained when quantitative methods are used.

The third most important characteristic of qualitative research has to do with research strategy on the generation of theory or hypotheses. As indicated elsewhere in this chapter, quantitative researchers are far more concerned with the formulation of hypotheses before any research can be undertaken. Such clearly formulated hypotheses are necessitated by the orientation of quantitative methods which are concerned with prediction and specificity. Qualitative researchers on the other hand, will view the imposition of a preconceived theoretical framework as undesirable because this may exhibit a poor fit with the perspectives of those whose experiences are being investigated (Du Toit, 1992; Wertz, 1985). By going into the research with no preconceived theoretical frameworks, qualitative approaches could thus be seen as relatively flexible, generally open and thus less structured. Such an open ended research strategy enhances the opportunity for chance discoveries (Crabtree & Miller, 1992; Huysamen, 1994).

5.3. The phenomenological approach

5.3.1. Edmund Husserl and the beginning of phenomenological psychology

Coined in the middle of the eighteenth century, the word phenomenology as a philosophy has assumed a variety of meanings when used by various philosophers like Kant, Hegel, Brentano, and Strumpf. For example, in advancing his theory known as phenomenalism, Kant (in Misiak & Sexton, 1973, p.2) distinguished between phenomena (that which appears) and noumenon (the thing itself). Kant made this dualistic contrast a cornerstone of his theory by arguing that our knowledge is restricted to the appearance of things (phenomena) and not that which is (noumenon).

Opposed to the naturalism of the positivists, Edmund Husserl (1977) supported Kant and other philosophers who argued in favour of phenomenology as an appropriate science of phenomena. However, unlike Kant who believed in the inaccessibility of that which is, Husserl was of the view that this higher level of reality can be reached through the study of

consciousness. Scientific inquiry, he maintained should begin with the phenomena of consciousness since these are the only 'givens' or material at our immediate disposal. By interrogating these 'givens' the researcher is poised to gradually get "back to the things themselves" (Husserl, 1977).

Influenced by the many philosophical undercurrents and notably by Frantz Brentano, Husserl expanded on his theory by adding that consciousness always intends an object. In other words, consciousness is always directed at that which is not consciousness itself. To use the words of Misiak and Sexton (1973): "There is no love without someone or something loved, no desire without something desired, no perception without something perceived and so forth" (p. 9)

The above analysis suggests that we can in theory ultimately know the object of consciousness (that which is intended by consciousness) by knowing the contents of consciousness. In Husserl's (1977) view, phenomenological method could systematically recover these contents of consciousness and thus help the investigator to arrive at the knowledge of the things themselves. This systematic process of recovery, Husserl maintained, would proceed from original intuition to a two fold process of eidetic and phenomenological reduction. By original intuition, a phenomenologist uses that which manifests itself in bodily presence (i.e. the immediate vision) to seek the ultimate foundation of that which is being investigated. By subjecting that which presents itself to intuitive reflection, the researcher paves the way for eidetic reflection which involves moving from the realm of facts as originally presented to that of general essences. As Kockelman (1967) wrote "[eidetic reduction] is the methodic procedure through which we raise our knowledge from the level of facts to the sphere of ideas". (p. 30)

Following closely on this phase is phenomenological reduction which moves the researcher from the general essences to the ultimate presuppositions. The successful practice of this two fold process of reduction requires "bracketing" or freeing oneself from any preconceptions, biases, beliefs, and habitual modes of thinking. Husserl (1977) called this suspension of all ideas and beliefs "epoche".

The many phenomenologically oriented psychologists who were influenced by Husserl further broadened on his ideas, and some like Amedeo Giorgi (whose work will be reviewed shortly) even went further to refine his theoretical arguments and to propose a step by step method that should be followed in phenomenologically inspired psychological research.

5.3.2. Amedeo Giorgi and phenomenologically based psychological research

Two most important developments, apart from the influence of Husserl's work appear to have encouraged Giorgi to present phenomenological psychology as an alternative theoretical and practical approach that could appropriately launch psychology as a human science.

Firstly, Giorgi (1985a) was not happy with the dominance of philosophical phenomenology among those psychologists who were trying to infuse phenomenological thought into psychology. In his view, a phenomenological psychology worth its name had to seek a way of breaking away from philosophical phenomenology if it hoped to develop its own identity.

Secondly, Giorgi (1970a; 1970b; 1971a; 1971b; 1971b; 1975; 1979; 1983; 1985a; 1985b; 1986) consistently challenged traditional psychology's natural scientific approach on the basis that such a psychology is out of touch with what is supposed to be its subject matter. A psychology premised on the natural scientific paradigm, he maintained, would not provide a faithful understanding of human phenomena.

Given these important developments, Giorgi (1985a, 1985b) felt there was an urgent need to develop a theory and practice of phenomenological psychology that would accurately investigate and describe phenomena as lived by people in the life-world. I will liberally quote Giorgi (1985a) at this point to reflect his deep concerns:

"Phenomenological psychology needs to break away from philosophical phenomenology in the same way as psychology differentiated itself from philosophy in general. I would say that a genuine phenomenological psychology does not yet exist in the sense of a community of psychological scholars who share research interests and strategies with a tradition in the same sense as, say, the verbal learning tradition or

psychoanalytic movement despite their controversies and heresies. Just why this does not yet exist is hard to say in full, but in my opinion, a large part of it results from the fact that phenomenology is understood primarily as a philosophy (which it is) which has implications for psychology rather than actually developing into a phenomenological psychology. Only the latter development will be able to make the impact on psychology that we are seeking. A genuine phenomenological psychology will have to be defined along with the development of a phenomenological psychological research" (p. 5).

Faced with the daunting task of having to demonstrate the viability of phenomenological psychology as a theoretical perspective and its applicability as a research praxis, Giorgi (1985b) undertook a study (using the phenomenological praxis) to discover what constitutes learning for ordinary people. Using descriptions given by subjects of their own lived phenomena, he tried to demonstrate how rigor and scientific discipline could be applied without necessarily having to transform data into quantitative material. It was mainly through this study that Giorgi (1985b) developed a research method that followed four essential steps

In the first step, the entire description given by the subject is read in order to get a general sense of the whole statement. In the second step, the researcher goes through the entire description once more with the aim of isolating "meaning units" that would be expressed mainly in the subject's phraseology in order for the data "to speak for itself" (Kruger, 1988, p.153). In the third step, the researcher rigorously reflects on the "meaning units" and expresses the psychological insight contained in them more directly. In the fourth step, which can be broken down into a number of levels, the researcher synthesizes all the transformed "meaning units" into a consistent statement regarding the subject's experience. Very crucial during this step is to turn the synthesized descriptions into a general psychological structure that would be communicated to the world of critical opinion.

I will again refer to the above steps in the next section when I give an outline of the method that was used in the present study. In a way of demonstrating its independence more concretely, Giorgi (1975) identified eight characteristics of phenomenological psychology. What

follows now is a brief review of these characteristics

a). Fidelity to the phenomenon as it is lived: This means that all descriptions reflecting the subject's lived experiences are considered an important source of data for analysis. Equally important here is the need to make explicit the perspective of the researcher as this is seen to have a bearing on the research situation.

b). Primacy of the life-world: In order to capture the subject's lived experiences, the researcher will need to go back to the life-world in which the subject is embedded. This should provide the necessary point of departure in terms of a research undertaking. To quote Giorgi (1975) at this point:

"By the life-world phenomenologists mean the everyday world as lived by all of us prior to explanations and theoretical interpretations of any kind. Since the life-world is the ground for all science and systematic knowledge, psychology conceived as a human science must always stay in touch with this inexhaustible source of all data" (p. 99).

c). Descriptive approach: Because of its reliance on what is communicated by the subject in the form of language, phenomenological psychology needs to rigorously analyze the descriptions given in order to understand human phenomena. This point has been extensively covered by Giorgi in his subsequent writings (see Giorgi, 1986, 1994).

d). Expression of the situation from the subject's viewpoint: In setting up a structure of research, phenomenological psychology is very much concerned with the subject's viewpoint. The point that Giorgi tried to raise here is that rich data can best be obtained if the subjects are given the freedom to choose their own examples of lived experiences.

e). Situation as unit of research implies a structural approach: Since phenomenological psychology accepts the lived situation as the basic unit of research, there is a need to take into account the interpersonal context that is created by the very act of investigation. Understood from this angle, it therefore becomes imperative to consider the exchange between the researcher and

subject when research data is interpreted.

f). From the personal to the general: Giorgi (1975) tried to draw a line between traditional experimental psychology and phenomenological psychology in terms of how theoretical concepts are formulated. Unlike the former which tends to formulate its concepts before undertaking the investigation, phenomenological psychology seeks to develop these concepts after contact with the data. In this sense, phenomenological psychology would start with personal accounts of the subject and on the basis of these gradually generate and construct theoretical positions.

g). Search for meaning: While the measurement method in scientific research is generally regarded as an important route, phenomenological psychology seeks to directly get to the meaning of the phenomenon without necessarily having to go through the measurement process in the strict sense of the word. "The value of the phenomenological approach is the direct access it provides to meaning by interrogating the qualitative aspects of the phenomenon" (Giorgi, 1975, pp.101 - 102).

h). Engaged researcher: Whether or not the researcher should play an active role in the constitution of the data has been a debatable issue in psychological research. A question is often asked: Should the researcher play an active role in the creation of the data or should he / she treat the data as self-made and complete in itself independent of the investigator? Though he is not in favour of taking an extreme position on this matter, Giorgi (1975) is of the view that phenomenological psychology should treat the results of a scientific inquiry as products of an engaged researcher.

5.4. Phenomenological method and the present study

5.4.1. The research setting and the participants

While acknowledging the difficulties of obtaining an ideal research setting, various studies tend to agree that a good research site should be accessible and unobtrusive (Bogdan & Bilken, 1982; Bogdan & Taylor, 1982; Burgess, 1984; Schatzman & Strauss, 1973; Spradley, 1980).

It was in consideration of the above factors that, for the purposes of the present study, I selected a rural district situated approximately 40 kilometres south of Tzaneen (a small town in the Northern Province). Known as Naphuno¹, this area is one of the 13 districts that previously constituted the now disbanded Lebowa homeland. Covering a radius of approximately 30 kilometres and with a population of about two hundred thousand people (based on the 1991 national census), Naphuno is divided into six sub-districts each with a local government structure headed by a "kgoshi". There are about 60 villages in total that make up this rural and agrarian district. Born and bred in the area, and thus being familiar with the culture and language of the inhabitants, I considered this district to be a reasonable research site for the present study.

Having identified the research site, I then moved on to consider items of sampling. In choosing the indigenous healers who participated in this study, the following guidelines as laid down by Kruger (1988) were followed;

- # Those who participate as subjects should have had experience relating to the phenomenon to be investigated.
- # The subjects should have the same language as the researcher, since this will obviate possible loss of subtle semantic nuances owing to the need to translate from one language to another.
- # The subjects should express a willingness to be open to the researcher and further have the ability to verbalize the data of their awareness. In addition, such participants should preferably be naïve with respect to psychological theory since familiarity thereof may interfere with the subject's account of the lived experiences.

The choice of the four indigenous healers who participated in this investigation was thus informed by these considerations. The known sponsor approach, as proposed by Patton (1990), was considered an appropriate mode of gaining access to the indigenous healers. By this approach, the researcher uses the legitimacy and credibility of another person to establish his / her own legitimacy and credibility. An example that can be given here is that of a researcher who would go through credible student organizations in order to study certain aspects of student life.

In the present study I decided to approach my prospective subjects by requesting my mother (who has been a practising indigenous healer in the area for over 20 years) to identify any popular and authentic indigenous healers that she knew of. She listed four such healers who I then decided to interview. These four indigenous healers were accessible in the sense that they were all within a radius of 20 kilometres from my village.

5.4.2. The interviews

In order to gain easy access and to establish rapport, I requested my mother to accompany me during the first visit that I made to each indigenous healer. Each indigenous healer received a total of five visits. After the introductions, I would state the purpose of my visit more or less in the following way:

"I am presently making an investigation of the practice of indigenous healing as a requirement for a postgraduate degree at the University of Cape Town. As an indigenous healer, I would like you to assist me by responding to the questions that I intend asking you. Your responses will give me an idea of how you go about your work as an indigenous healer. I will specifically want to find out what happens from the moment when a patient comes to consult with you for the first time up to the time when you will declare him / her to be feeling okay. What is important is for you to indicate to me what this whole practice and process mean to you. I will record some of our conversations on an audio-tape".

Having thus negotiated for a research role, I would spend the remaining hours of my first visit familiarizing myself with the environment at the indigenous healer's place. The audio-taped interviews took place on subsequent visits. The dates and times for such recorded interviews were picked up at random. The interviews were unstructured and these were conducted in accordance with the guidelines provided by Hagan (1986) and Kvale (1983).

According to Hagan (1986), in-depth (unstructured) interviewing is not a mechanical procedure which can just be applied across a sample of respondents. She emphasized the need for an open, genuine and sympathetic approach which treats the interview as a personal

encounter. In this regard, it is important for the researcher to listen to what comes without selectively testing hypotheses. In other words, the researcher should maintain an air of naturalness and spontaneity while at the same time taking a non-categorizing approach to what is taking place in the interview situation.

Hagan's (1986) sentiments were echoed by Schurink (1988) who saw the researcher as someone whose role is mainly:

"... to introduce the general theme on which information is required, motivate the subject to participate spontaneously, stimulate through probing, steer him (her) back tactfully to the research topic when he (she) digresses" (p.139).

While on the average each audio-taped interview with the indigenous healer lasted for about two hours, the discussion would normally go on until up to a point of saturation, that is, when interviewing revealed no more new perspectives on the topic under discussion.

5.4.3. Analysis of the data²

The four audio-taped protocols obtained were transcribed and then translated before they were analyzed in terms of the four phases of phenomenological explication as set out by Kruger (1988). These four phases are as follows:

a). Sense of the whole: During this phase the text should be read several times with two specific goals in mind: i). to understand the language of the describer, and ii). to get an intuitive and holistic grasp of the data. What is basically required of the researcher at this stage is to remain faithful to the data by avoiding any temptation to analyse the protocols in order to derive psychological insight. Appendices A to D contain full transcripts of the audio-taped interviews with the four indigenous healers.

b). Discrimination of "natural meaning units" (NMU's): The second phase requires the researcher to break down the text into naturally occurring "meaning units" that will be manageable and easy to analyze. According to Cloonan (1971, p.117) a "natural meaning unit" may be defined "as a

statement made (by the subject) which is self-definable and self-delimiting in the expression of a single, recognizable aspect of [the subject's] experience".

The researcher should then articulate the essence of these NMU's using the subject's phraseology as much as possible. According to Giorgi (1985), it is important for this process of articulation (of NMU's) to occur within the context of discovery rather than that of verification. In the present study the text was similarly broken down into NMU's which are numbered and presented in Chapter Six.

c). Transformation of NMU's into central themes: During this phase, the researcher starts by rigorously reflecting on the NMU's which are still in the ordinary language of the subject. According to Kruger (1988), this act of reflection is intended to transform the NMU's into central themes that are expressed in psychological language.

A related activity to rigorous reflection is that of imaginative variation whereby the researcher reflects on the imagined possibilities inherent in each central theme and discards those that fail to withstand criticism. Giorgi (1985b) and Wertz (1985) do however warn that this process of imaginative variation is bound to lead to tension between the specifics of ordinary descriptions and the more psychological categories that the researcher is trying to put together. In addition, it is possible that different interpreters of the protocols could differ in terms of the degree to which they may want to transform these ordinary descriptions into psychological language. It is only by going through this process despite its tensions and the possibility of more than one interpretation that the researcher will ultimately arrive at psychological statements which express the subject's intended meaning.

With the principles articulated above in mind, the researcher in the present study made an analysis of each subject's protocol and presented the emerging central themes side by side with the NMU's in Chapter Six.

d). Synthesis of central themes into consistent psychological structures: This last phase of the process of phenomenological explication is divided into two steps as recommended by Kruger (1988).

During the first step, all the central themes are synthesized to communicate the psychological insights contained, taking the particular context of the experiencing individual into consideration. In Part A of Chapter Seven, I will present these context-bound descriptions of each of the protocols.

During the second step (which is presented as Part B of Chapter Six), all the psychological insights contained in the specific descriptions are put together to develop a general description of the process of indigenous healing. Kruger (1988) makes a clear distinction between step one and two of this fourth phase as follows:

"While the specific description is one which communicates - through a psychological perspective - the unique structure of a particular phenomenon within a particular context, a general description is one which communicates the meaning structure of a phenomenon in general and which attempts to overcome the limitations imposed by any context" (p.154).

Like in the case of phase three, the researcher in phase four is also bound to deal with some tensions that will arise from the process of transforming insights from the specific to the general.

Notes

- 1 Naphuno - With the new political dispensation that was introduced in 1994, new boundaries are being demarcated to cater for the elected transitional local councils. As the situation stands currently, a part of Naphuno falls under the Hoedspruit Makhutswe Transitional Local Council whilst the other portion falls under Greater Letaba Transitional Local Council. The issue of boundaries, both at local and provincial government level, is a hot debate at the moment as some communities are resisting

incorporation into some provinces.

- 2 It should be kept in mind that Giorgi's phenomenological research (that guided the researcher in the present study) was done exclusively on people in western countries and the United States of America. It is therefore possible that a western oriented psychological language that has been used in the present study may have not adequately represented some of the experiences of the indigenous healers.

CHAPTER SIX
PHENOMENOLOGICAL EXPLICATION

6.1. The case of Josephine

Josephine is a fifty five year old woman who lives in a village called Mogapeng. Like in the case of all the other villages in Naphuno, Mogapeng is under the jurisdiction of a headman who in turn reports to a "kgoshi" (traditional leader) by the name of Mogoboya. As it is the case with many other women of her age in the area, Josephine has hardly been to school. She went up to Grade B but had to stop schooling because, as she puts it: "My parents did not encourage me to continue schooling because they felt that a girl child would be married and move away". Josephine got married when she was 21 years old but she and her husband got divorced five years after the marriage because he (the husband) wanted to marry another woman. At the time of the divorce, Josephine had two children. Three years later, Josephine developed a relationship with another man who fathered two of her four children. Josephine regards herself as a fully fledged indigenous healer who sees an average of two clients per week. Most of her clients come to consult her in the morning hours on weekends. Since the income from her practice is inadequate, Josephine sells fruits and vegetables from her homestead. Josephine and the researcher's mother met and got used to each other many years ago as a result of their involvement in the activities of Madupe Traditional Healers Association - one of the several associations organising indigenous healers in the area.

A. NATURAL MEANING UNITS	B. CENTRAL THEMES
1. Okay, I will give you a full explanation [of how I became an indigenous healer]. I am told that after birth I spent four years unable to walk. Because of their Christian principles, my parents were reluctant to take me to indigenous healers in order to establish why I could not walk.	1. Even at a very early age, there were signs of an ancestral "call" made to J to become an indigenous healer. However, this "call" was disregarded by J's parents because of their Christian beliefs.

2. After some time, a certain indigenous healer came to my place and asked my parents why they were not taking me to indigenous healers for treatment. I am told he somehow managed to convince them to perform certain rituals which ultimately led to my recovery.

3. As far as I can recollect events of my childhood, I have always been having strange dreams. Just to give you one example, I used to have unpleasant dreams during which I would see people that I know very well dying. These dreams would come true as these people that I will have had dreams of would die. These dreams worried me so much and I got scared.

4. I remember even going to the church with the hope that being a churchgoer would help rid me of these strange and unpleasant dreams. I appealed to the priests to help me get rid of these dreams but to no avail.

5. The dreams persisted and gradually I was also shown some medicines that could be used to help those who are sick. The ancestors would guide me on how I should mix the herbs as well as the person who I would have to help.

2. The persistence of J's problems and a visit by a person carrying traditional authority (in the form of an indigenous healer) shakes her parents' religious beliefs as they reluctantly become receptive to the idea of seeking the services of an indigenous healer.

3. J had premonitions as revealed by her dreams which she experienced as strange and worrying.

4. J found the power associated with her dreams to be disturbing. This led her to seek help from the church.

5. Through the dreams that are associated with the ancestors who guide her, J begins to develop some skills that she applies in helping those who are sick.

6. My dreams and constant contacts with my ancestors soon became problematic as my parents did not approve of my experiences. They thought I was just a naughty child.

7. I remember one particular incident that, to a large extent, changed my parents' attitudes and got them to take me serious. After a number of years in a marriage, my sister-in-law could not conceive. Her failure to conceive was causing a lot of friction in our family as my brother was beginning to blame her for failing to bear him children.

8. One day as I was asleep, my ancestors visited me and instructed me to go and collect some herbs that I would administer to my sister-in-law. When I narrated this dream to my parents the following morning, they just dismissed me and even warned me not to pester them with what they dismissed as silly dreams. I then decided to disobey them and went ahead to explain my dream to my sister-in-law. She was so excited that she literally begged me to do as I was instructed by my ancestors. I went on to collect the herbs as directed. I mixed and administered the medicines to her. After a short while, she did conceive and gave birth to a healthy girl.

6. J's parents reject her new interpretation and continue to disregard her experiences.

7. J remembers an experience that changed her parents' attitudes and transformed their relationship with her.

8. J considers her dreams to be so important that she begins to take them seriously and to carry out the instructions given by the ancestors despite the fact that her parents disapprove of this. Her interpretation is further validated by her sister-in-law who gets excited when informed about the dream.

9. After that experience, I started having more dreams and ancestral instructions on who I should help. Mind you all these healing activities were taking place before I received formal training as an indigenous healer. It was all just a matter of ancestral guidance.

10. In 1972 I had a strange experience that eventually changed my life. It was just one ordinary day and I happened to go to the nearest river to do some washing. Whilst doing the washing, I somehow lost my consciousness and fell into the water. What exactly happened thereafter is difficult to tell as I only regained my consciousness at home.

11. Shocked by this incident, my parents invited a local priest to come and pray for me. When the priest's interventions did not help, and also upon the insistence of my uncles and aunts, my parents did finally invite one local indigenous healer. On arrival he threw his divination bones and advised that my strange behaviour was an indication of a call to become an indigenous healer. He referred me to another indigenous healer who had a good reputation of training

9. Positive results with one case leads to more dreams and even more positive results even though at this stage J is still not formally trained as an indigenous healer. J's communication with the ancestors became more active as she started having more dreams about how to help those who are sick.

10. The year 1972 marks a turning point in her life as J experiences a temporary loss of consciousness whilst doing washing in a river.

11. J's sudden illness prompts her parents, uncles and aunts to come together and engage in help seeking behaviour which involves consultation with an indigenous healer after unsuccessful attempts by a priest.

people to become indigenous healers.

12. I went through the training programme and on my return home at the end of 1972, I was a fully fledged indigenous healer. [The] training lasted for four months. On the fifth month I was taken home. It took me such a short time to train because my ancestors had already guided me for a long time before the actual training. I would say my training was to a large extent a way of formalizing my status as an indigenous healer.

13. A person who is called to become an indigenous healer is not like someone who goes to a driving school to obtain a driver's license. In the case of a driver's license, you simply decide when you feel ready to learn to drive. In our case it is the ancestors who decide on the person who should become an indigenous healer and also when such a person need to undergo training. It is unthinkable in our culture to [train without being called]. Our training is different from that obtaining in Western culture where the medical profession is joined by those who choose to do so. In the case of indigenous healing, you have to be called by the ancestors.

12. Through a series of procedures, including "visits" by ancestors and a period of formal training, J's status changes as she adopts a special role of indigenous healer in the community.

13. The gate-keeping task of who and how one joins the ranks of indigenous healers is seen as ancestral prerogative and not a matter to be decided by an individual. Becoming an indigenous healer is not just a profession, but it has to be a calling by ancestors.

14. I do treat many types of illnesses. In Western medicine there is what they call stroke. In our terminology we refer to this condition as "sefolane". I know how to treat cases of "sefolane", infertility, and various types of venereal diseases. I have also treated a lot of cases of mental illness. In addition, I do train people to become indigenous healers.

15. These days people talk of Aids. My understanding is that this disease is transmitted through sexual contact. If the hospital could give us the opportunity, we as indigenous healers would help treat this condition. Unfortunately the medical professionals do not want to refer their patients to us. If there could be a better referral system between the hospitals and indigenous healers, a lot of Aids victims could be helped before their conditions become chronic. If these doctors could stop being selfish we could both help the people.

16. There are many ways of assessing [treatment] outcomes in our practice.

17. I will give you an example of how we deal with a mentally disturbed person. Normally such a patient will be brought to

14. J perceives herself as competent enough to deal with various types of clients who may present with emotional and physical problems.

15. J gives a hopeful prognostic picture of Aids and goes on to communicate a desire for closer collaboration between indigenous healers and Western trained health professionals.

16. Treatment¹ outcomes are assessed in a number of ways.

17. The process of assessing² and treating what is identified as mental illness is a systematic process which is informed and

us by relatives who will usually complain that he is aggressive, running around, talking irrelevantly, hearing voices, hoarding, and so on. On arrival here I will consult my ancestors [through the divination bones] to advise me as to the nature of the problem as well as suggesting to me the appropriate form of treatment. I will then follow these guidelines and start treating the patient.

18. To show that the patient is beginning to improve you will see him beginning to "swaba" (to be shy) and to realize that he is shabby and not properly dressed. I will then send him to the local shop to buy me one or two items. This exercise is intended to establish if the patient is beginning to get his senses back. If he is still disturbed he will fail to follow my instructions. He will come back with the money without the items that he was supposed to buy.

19. On the other hand if his condition is improving, he will come back with the items as instructed. How the patient relates to these simple instructions will give me an early indication of how his condition is progressing.

20. If I am getting satisfied with progress

guided by spiritual forces.

18. Shyness is one of the early signs that J identifies in those who present with what she understands as mental illness. Through observation, J will establish if the patient³ is beginning to have contact with reality.

19. By giving tasks that involve a series of instructions, J examines if a client is getting his senses back.

20. More complicated tasks that require a

and if the patient is following the instructions, I may decide to send him to town to buy me a number of items. If he comes back with every item as directed I will get the impression that he has improved.

21. You see, the medicines we use are very effective. It takes only a few days before the patient begins to "swaba".

22. Usually it is at this point that I will invite his relatives to my place to come and have their own assessment of the patient. In their presence, I will request the patient to perform certain tasks. A patient who has recovered will start by greeting the relatives and even get into a meaningful conversation with them. He will ask them about how they are doing and how everybody at home is feeling.

23. Normally I will request such a patient to perform certain tasks in the presence of the relatives. After a while, I will ask them to give their own impressions of the patient's condition. They will communicate their impressions to me. All these tasks that the patient is requested to perform are meant to test his ability to relate to the relatives and to

relatively high level of adjustment and contact with reality are gradually given to those patients who appear to be making good progress.

21. J has a strong belief that her medicines are potent enough to bring speedy recovery to her patients.

22. Before a patient is discharged, the significant others in his life are invited to make their own assessment of the progress made. J uses this opportunity to make further clinical observations.

23. In the presence of the relatives, J assigns more tasks to the patient so that they too can assess the patient's level of contact with reality (more especially) in interpersonal relations.

judge if his condition has improved.

24. If his relatives are satisfied, I will then start making preparations to send the patient back home. Before this is done, the patient will have to be "hlapiswa" (cleansed) and "thekgwa" (protected).

25. Even before I take [the patient] home, I have to go to his place and "thekga" (protect) the homestead.

26. You see, if a person is mentally disturbed, it is like he is deceased. Recovering from mental illness is like coming back from the dead. So we have to "hlapisa" this person to remove the "senyama" (bad luck) or "leswiswi" (darkness). It is like we are removing the heavy yoke from his shoulders and also taking off his "letlalo la ditshila" (dirty skin).

27. Having brought him back and with a new skin, such a person has to be "thekgwa".

28. In our vocabulary "senyama" has got many meanings because it is caused by a wide range of things. It may roughly be

24. Convinced that the patient is fairly in touch with reality, J carries out further treatment procedures that involve the use of medicines to cleanse and protect the patient.

25. J extends her interventions to cover members of the patient's family by also directing her interventions at the homestead.

26. Treating a mentally ill person is a fundamentally reconstructive activity that is likened to "bringing somebody back from the dead".

27. J once again emphasises the significance of protective medicines.

28. J perceives "senyama" as a real and highly contaminative condition of ill-health that has a number of causes.

understood as darkness or bad luck.

29. For example, if you attend a funeral, you get "senyama". This kind of "senyama" can only be rubbed off by washing your hands before you leave the deceased's home. Failure to do so will lead to a contamination that may be detrimental to the health of your family.

30. A woman who has had abortion or miscarriage is also having "senyama". A man who happens to have sexual contact with such a woman will be contaminated by the "senyama". Such a contaminated man or woman is a hazard to the health of other people, more especially children and livestock.

31. A person who is mentally disturbed is also having "senyama". His body is contaminated. It needs to be cleansed to rid the patient of this contamination. It is as if he is dead because he does not realize that he is out of touch with reality and behaving inappropriately. He may use a container that is leaking to fetch water without realizing that his action is inappropriate. His sense of judgement is gone. He is mentally disturbed. As soon as his condition improves he will

29. Non-compliance with funeral rites is given as one of the causal explanations for "senyama".

30. Heedless sexual conduct is perceived as another causal explanation for "senyama" which can spread to affect other family members and livestock.

31. The third causal explanation for "senyama" is mental illness.

realize that his behaviour is inappropriate. In other words, he will begin to be himself and to have a good sense of judgement.

32. If [a person with "senyama"] is not cleansed he will never recover. Even if he may stop showing the flagrant symptoms like aggression, he will appear to "swaba" and to show poor eye contact.

33. If we discharge [a mentally ill person] while he is still in this state, he will fail to relate to others when he gets back home. If he is married, he will be too shy to even suggest having sexual relations with his wife. This may lead to problems as the wife may even be forced by such a situation to take the initiative.

34. After all these procedures that are aimed at the patient have been performed, we have to go to his place to "aga motse" (protect the homestead). We have to do so because it is as if his homestead has been struck by lightning. The homestead has been destroyed and has to be rebuilt in order to be habitable. Obviously we can not take such a person to these ruins. We have to rebuild what has been destroyed and to make sure

32. J emphasises the significance of getting the patient cleansed in order to remove "senyama"

33. J is of the view that a patient who is discharged whilst not cleansed will not cope adequately in social and heterosexual relationships.

34. J interventions are extended to cover members of the patient's family by also directing her interventions at the homestead.

that the lightning does not strike again. The protected homestead will also make such a person strong and confident as soon as he gets back.

35. [The aim of our treatment is to] help everybody in the homestead, including the wife, children and even the livestock and crops. When we say that the person is okay, we are also saying that his home, his children and his belongings are okay. If we do not address the entire home environment, he will get sick again and come back to us. We obviously do not want to see such a situation. So we have to go and fix his place before he is taken back.

36. [The patient's] relatives will be expected to organize transport for me. On arrival at the patient's home I will perform the necessary rituals and shortly after that I will take the patient home.

37. I will usually give the relatives a period of three to four months to observe the patient at home in terms of how he relates to them. What I have often seen is that the relatives will normally approach me even before the three or four month period has elapsed to thank me for the services

35. Good health is interpreted by J as an holistic experience that exists when there is harmony between the individual and his family, and between human beings and their environment.

36. An undertaking is made by the patient's relatives to invite the indigenous healer to help restore a harmonious relationship between themselves and the environment.

37. Further observations on the patient are made by his relatives who will be expected to give J some progress report after a few months.

rendered.

38. [The patient's relatives] will often invite me to visit them again and to celebrate the good health that I will have restored to their lives and family. During such visits, I will again spend some time with the patient trying to assess if he has fully recovered.

39. When the patient arrives here the first step is always to throw the bones and to establish the nature of his problem. The "ditaola" (divination bones) will always tell me exactly what the cause is and also how I should treat the patient.

40. If it is a problem like mental illness I will advise the relatives to leave the patient in my care until he will have improved. On the other hand, there are problems that may not warrant a patient's stay at my place. In such mild cases I will usually prescribe medication and advise the relatives to come back for follow up treatment after some time.

41. The divination bones are my extra eyes. They will indicate many things to me. From the fall of the bones I can tell everything about the patient.

38. Even after a patient will have been discharged, J gets an opportunity to make follow up visits.

39. Through the use of an assessment process that involves the use of divination bones, J is in a position to assess the nature of the problem and to recommend an appropriate treatment / preventive programme.

40. J uses her skills to decide on whether or not a consultee will need to be admitted for treatment and closer supervision.

41. J has confidence in her assessment procedures on which she heavily relies whenever she sees a patient.

42. There are many other [methods of divination]. The method that a particular healer uses will always be determined by his ancestors. There are other indigenous healers who can arrive at a diagnosis without using the divination bones.

43. For example, there is what we call divination by "moya" (spirit). In this case, the diviner will work like a prophet and tell you what they see. There are still many other diagnostic methods like divination through the use of water and a cloth.

44. There are some indigenous healers who will combine a number of diagnostic methods because they will have been directed to do so by their ancestors.

45. [As indigenous healers we] are always guided by the ancestors. Just to give you an example, even before you came to visit me I saw that from my dealings with the ancestors. They did indicate to me that somebody special would be coming to pay me a visit. So I was not surprised when you arrived and requested to interview me.

46. My ancestors guide and indicate to me the kind of people who will be coming to

42. J again sees spiritual beings as central during assessment and treatment.

43. Some indigenous healers are perceived as having the ability to, for example, read a patient's condition from a piece of cloth.

44. More than one assessment method may be used with one patient.

45. J has an unshakable belief that she does communicate with the spiritual beings who provide guidance when she relates to those around her.

46. The spiritual guidance is believed to help J in assessing her patients.

see me. If it is a patient who is supposed to be coming to see me, my ancestors will even show me the nature of his problem. When he arrives here I will be ready.

47. Everyday before I go to sleep I will sprinkle a little snuff on the floor and talk to my ancestors. I will tell them that as I fall asleep I would like them to come and guide me on how best I should treat my patients.

48. Sometimes they will advice me to review medication for some of my patients and suggest the form of treatment that I will have to prescribe for the patient. I have to follow all these advices.

49. Right from the beginning, we have been unfairly treated by white people who have always referred to us as witchdoctors. This label has over many years antagonized our relationship with the people we are supposed to serve. The simple truth is that we are not witchdoctors.

50. Some of our people are now beginning to believe these white people and they often appear to be surprised when they see an indigenous healer being successful in life. They tend to forget that as indigenous

47. There is constant dialogue that J actively and purposefully maintains with the spiritual world for the sake of her patients.

48. The spiritual guidance is again believed to help J in deciding on an appropriate treatment programme for a patient.

49. The title of witchdoctor is inappropriate and seen as an imposition by those from other cultures.

50. Over the years some of the people J is supposed to help have been indoctrinated by aliens into becoming suspicious of indigenous healers.

healers we get paid by our patients. They also fail to appreciate that as indigenous healers we are on duty 24 hours a day as patients visit us any time.

51. The wrong perception that has been created needs to change. I remember last year there was tension in the area of "kgoshi" (chief) Sekororo. A section of the youth was accusing indigenous healers of being witches.

52. We were all called to a meeting with the youth. I stood up and warned all the youth never to trouble the indigenous healers. I gave them an explanation of what indigenous healers do. I explained to them that indigenous healers perform a lot of valuable functions in the community which, among others, include rain making, treatment of the sick, and acting as special advisors to the "kgoshi".

53. By the end of the meeting all the young people were happy with us. Since then the problem has been resolved.

54. Indigenous healing is part of our culture. We just have to stick with it. There is no

51. The suspicions developed bring tension to the community.

52. J takes it as her responsibility to correct the misconceptions and to ease the community tensions that are brought about by the suspicions.

53. J succeeds in diffusing community tensions.

54. J is very committed to her practice which she perceives as a valuable cultural

way some of us can run away from our responsibility as indigenous healers.

55. Right now, if I happen to get sick I will not just go to the hospital without informing my ancestors first. Failure on my part to communicate with my ancestors before taking such a step may result in bad consequences.

56. For example, if without having informed my ancestors I receive an injection from the hospital, I will develop a lot of complications. Always before I go to hospital or anywhere outside my village, I have to throw a little snuff on the floor and say something like this: " My grandparents, I am taking a trip today, do not be surprised. I would like you to lead me all the way and to bring me back home safely". If this message is expressed, my journey will always be safe.

57. As I am talking to you now [the ancestors] are guiding me as to what I should tell you. They protect me all the time. That is why I told you last time that there is no one I can trust more than the ancestors.

58. If the patient is an epileptic [and receives

institution worth preserving.

55. In her own private life, J continues to actively maintain constant dialogue with the spiritual forces.

56. Failure to dialogue with the spiritual forces may lead to disastrous consequences.

57. J has unshakable belief that she does communicate with spiritual beings who provide guidance when she relates to others.

58. Treatment is considered effective if a

our treatment] he will not have the fits any more. If he is mentally disturbed, he will no longer talk to himself. He will no longer fetch water with a basin that is leaking. If it is a person with a sexually transmitted disease we will no longer see him sweating excessively like before. The patient will become sexually active again.

59. Sometimes a person gets sick and stay at home for far too long until his condition has worsened. It becomes too difficult to treat such a patient.

60. On the other hand if a patient is brought to our attention during the earliest stages of the illness, he will not take long with us. Such a patient's chances of recovery will also be much better. If the condition is still acute, the patient may stay with us for 3 days or so. On the other hand, chronic patients will stay much longer with us before they recover.

61. [Making an assessment of whether one has been successful with a patient] depends on one's experience as an indigenous healer. I have been working for some years now and I can tell you when a patient is not making any good progress. After a week or two of

patient regains previous level of functioning.

59. Bringing a patient early for treatment is considered desirable as this stops a patient's condition from becoming chronic.

60. Chances of recovery for those conditions that are detected and treated early is much better.

61. Informed opinion of fellow indigenous healers is sought when J deals with difficult cases.

intensive treatment, I may decide to consult my peers for advice if I do not make any positive progress with that particular patient. I will discuss with my colleagues and solicit their opinions on how best to help the patient.

62. Sometimes you may find that the poor progress that the patient shows is related to some problems that do exist at his place. For example, it may be that there is dissatisfaction on the part of the patient's ancestors. If this is discovered to be the case, we will advise the relatives of the patient to perform the necessary rituals. Once this is done you will see the patient's condition improving.

63. Sometimes it may as well be that there is conflict in the family. We have to help extinguish this fire before we can allow the patient to get back home.

64. I also refer my patients to the hospital if this becomes necessary. If on assessment I get the impression that the patient's condition needs hospital medicines, I will not hesitate to refer the patient. Usually I will advise the patient to come back for my

62. Poor progress of a patient in treatment is at times attributed to strained relationships between the living and the ancestors. By performing the necessary ritual, the well being of the patient and his family will be promoted.

63. A family conflict is seen as another factor that may lead to poor progress in a patient's treatment.

64. I acknowledge the role of Western health institutions to which she occasionally refers cases beyond her competence.

treatment after he will have received the treatment from the hospital.

65. As indigenous healers we are not supposed to treat patients whose conditions are beyond our knowledge. Doing so will invite the wrath of the ancestors. We do cooperate and share our skills with others.

66. As indigenous healers, we have always been prepared to collaborate with Western trained doctors for the sake of our people's health. The problem though is that these doctors in the hospitals are not prepared to work with us. We do refer patients to them. Unfortunately they do not do the same in those cases where they fail.

67. For example, if a person has "sefolane" they will just keep him in the hospital until his condition is such that they will consider amputating the legs. Once the condition spreads to his arms they will go on amputating until the person will lose all the limbs. This is too bad.

68. If such a patient [with "sefolane"] is referred to us early, we can treat the condition without the person having to lose the limbs. If I diagnose "sefolane", say on

65. J feels it is improper (or unethical) to treat patients whose conditions one does not have the competence to handle.

66. J expresses a desire for closer cooperation between indigenous healers and Western trained health professionals. She further regrets the fact that Western trained doctors do not seem to be willing to work with traditional healers.

67. J questions some Western treatment methods, like amputation, which in her view are harsh and unnecessary for certain conditions.

68. Treatment of what J refers to as "sefolane" follows a series of steps intended to be curative and to stop the condition from spreading to other parts of the body.

my patient's left leg, I will first attend to the limb that is not affected in order to stop the condition from spreading. Once I have done that, I will then attend to the affected leg and administer the medicines.

69. Western doctors should stop this cruel tendency of always resorting to amputation. It is fairly easy for us to treat this condition.

70. ["Sefolane"] is a disease that comes in many ways. You may get it by crossing certain paths that you should not cross. You may be pricked by a thorn that has been doctored by those with evil intentions. You may get bitten by a snake that has been sent as a familiar by the witches.

71. A person with "sefolane" will show a swelling in the limb that has been affected. The swelling will keep on spreading to affect the other limbs and ultimately the whole body until the patient dies. Once this swelling is noticed by Western doctors, they will not hesitate to amputate.

72. My main duty as an indigenous healer is to help others. There are so many people out there who need help. We have been chosen by the ancestors to help these people. We are

69. J is very unhappy about the amputation of limbs as a treatment method.

70. J advances a number of causal explanations for what is regarded as "sefolane".

71. J understands "sefolane" to be a deadly physical condition that does, over a period of time, spread to affect the victim's entire body.

72. As an indigenous healer, J is dedicated to serve and not to harm others.

not witchdoctors as the white man is saying. If we had the intentions to harm others, where would we get our future clients? It would be as if we are killing ourselves.

73. "Malopo" is a condition that is brought to the living by ancestors either as a sign that they are happy or as an indication of their displeasure. Sometimes it may happen that one's grandparents die with a complaint. This will later emerge in the form of illness that will befall members of the family.

74. Once the illness has been diagnosed, the afflicted person must perform the necessary rituals that will culminate in a "malopo" dance.

75. The shaking and restlessness [of a "malopo" person] is an indication that the person feels the pain [and that his body has been invaded by the ancestors]. The spirits of the possessing ancestors have taken over the control of such a person's body. By taking over the body of the possessed person, the ancestors are trying to find a way of making their needs and wishes known to the members of the family. It is like they communicate with the rest of the family through the possessed person.

73. Ancestors are believed to communicate their satisfaction or displeasure through what is known as "malopo" illness.

74. Someone with "malopo" is expected to submit to the wishes of the spiritual forces by performing prescribed rituals.

75. Ancestors are understood to occupy the experiencing individual's body in order to communicate their messages and desires to the living.

76. The thing about ancestors is that you can not ignore them.

77. One thing interesting to note about "malopo" is the fact that the person affected will not be able to recollect the events after he will have been in the possession state. After this experience, the other people who witnessed the possession state will have to explain to the person who had been possessed as to exactly what happened.

78. [If you disregard ancestral instructions] you will get sick. The ancestors will punish you for showing disrespect. If you decide to ignore the call and, say, go to Johannesburg to look for a job, the ancestors will make it difficult for you to find employment. They will haunt you until you come back home. Things will just generally go wrong in your life. In the case of a married woman, she will find herself unable to conceive.

79. When such a person consults an indigenous healer to establish the reasons for the mishaps or problems, he will be informed about the disrespect that he will have shown to the ancestors.

76. J expresses her conviction about the existence of the spiritual beings who need to be obeyed by the living.

77. "Malopo" possession leads to clouding of consciousness after which the affected person will not remember what happened during the experience.

78. Failure to submit to the wishes of the spiritual forces may lead to occupational, social and emotional problems.

79. Indigenous healers have the skills to establish if a sick person's illness or mishaps are an indication of strained relationships with the spiritual world.

6.2. The case of Magdalene

Magdalene resides in a village called Sofaya. This is one of the several villages that are under the jurisdiction of Kgoshi Sekororo. Though not sure about her age, Magdalene appeared to be in her late 60s since she is receiving government old age pension. Asked about her children, Magdalene indicated that she has four daughters and three sons. All her daughters and one son have married and moved out of the family. Currently she stays with her husband, two of her sons and their wives, and 4 grandchildren. All the two sons who are currently staying with her are working in the Gauteng Province and only come home one weekend per month. The wife to one of the two brothers is a nurse at a local hospital while the other daughter-in-law is completing a teacher's diploma at one of the colleges in the Northern province. Judging by the lifestyle and the quality of the houses in the homestead, Magdalene's family seems to be financially stable. Like Josephine, Magdalene regards herself as a fully fledged indigenous healer who prefers to treat childhood illnesses and various gynaecological problems.

A	NATURAL MEANING UNITS	B	CENTRAL THEMES
1.	I have been practising as an indigenous healer for more than ten years.	1.	M is a fairly experienced indigenous healer if judged by the number of years she has been in practice.
2.	Before I became an indigenous healer, I used to have a lot of strange dreams more frequently. I did not take these very seriously until when I got very ill.	2.	Becoming an indigenous healer for M was preceded by strange dreams and an illness.
3.	I was taken to the hospital with the hope that my condition would improve. This did not help and after some time my aunt suggested that I be taken to an indigenous	3.	An illness experience prompts M's relatives to embark on help seeking behaviour which starts with a consultation at a Western health institution before the

healer.

4. On consultation the indigenous healer pointed out that I have been called by my ancestors to become an indigenous healer. I was trained for almost a year before I was sent back home.

5. The steps that one has to follow [when treating a patient] depend on the nature of the complaint that the patient is going to present with. It is thus very difficult to give a general explanation of the steps that should be followed if all the various illnesses are approached differently. Anyway, I will try my best to give you an overall picture.

6. The first step that we generally take when a patient comes to consult is to throw the divination bones. These bones will give an indication to us as to the nature of the patient's problems.

7. We do not expect the patient to tell us the nature of his problems. We can read all that from the fall of the bones. We do not guess the diagnosis. We can always read the diagnosis from the bones. We have to ask the bones and they will give us the green

services of an indigenous healer are sought.

4. What has been a disabling experience is interpreted as a "call" to become an indigenous healer.

5. The nature of the problem presented by the client determines the steps that the indigenous healer will follow in dealing with a complaint.

6. M is convinced that the assessment process which involves the use of divination bones, is to understand the nature of a patient's problem.

7. The assessment procedures that M uses are such that she does establish the nature of a problem without relying on a patient's explanation. The divination bones help her to know the nature of the problem.

light. Our intervention programmes will be decided by what the bones tell us.

8. I do not handle very complicated illnesses. My speciality is childhood ailments like "lekone" and headaches. I do also treat women who come to me with complaints about infertility.

9. In the case of Western medicine, there is what is called kwashiorkor. We call this kind of illness "metsho". A Western trained doctor will give his own kind of medicine. We have our own method of treatment for a child with such a problem.

10. Usually the child with "metsho" will cry for no apparent reason. He will also appear startled and at times he will complain about seeing monkeys and other strange animals. Such a child will become very restless and have difficulties in falling asleep. He will also be afraid of many other things that are otherwise harmless.

11. When a child [with "metsho"] is brought to us we will always start by throwing the bones in order to establish the nature of the problem.

8. M feels that she is better qualified to handle various childhood illnesses and gynaecological problems.

9. M acknowledges that her intervention strategies for conditions like "metsho" are different from those adopted by Western oriented health practitioners.

10. "Metsho" is understood by M as a childhood illness which is manifested in a number of ways including crying spells, restlessness and unwarranted fear of objects in the environment.

11. Through the divination bones, M establishes the nature of the problem that the child presents with.

12. We will then communicate our impressions to the parents and also advice them about an appropriate treatment plan. If they agree with our diagnostic suggestions, we will then prescribe the medicines that will help the child.

13. [To show that there is progress] the child will begin to have a sound sleep without all these imaginary perceptions of monkeys and other strange animals.

14. In the case of headaches, the parent will usually come and present the problem on behalf of the child. Like in the case of "metsho" we will first throw the divination bones in order to establish the nature of the problem.

15. [In the case of childhood headaches] the child will show a number of clinical features. The eyes will show a dull appearance. The child will vomit a lot and also have a running stomach. This happens to very young children who are less than five years old.

16. Once we have established the nature of the problem and a treatment plan we will look for the appropriate herbs that are to be

12. What is assessed as a problem is communicated to the child's parents who will then make their own decision on whether or not they would like M to offer treatment for the problem.

13. M has a system in place that helps her to assess treatment outcomes in the case of "metsho".

14. Like in other cases, the divination bones are used as a first step when a child presents with headaches.

15. M identifies several symptoms that she perceives as indicative of childhood headache.

16. M is convinced that her treatment procedures, which mainly involve the administration of herbal medicines, are

used to alleviate the child's problems. We burn such herbs and give to the child to "orela" (inhale the smoke). The residue of the burnt herbs is going to be prepared into a "tshidi" (ground ash) that will be mixed with the child's feeds. The medication given will soon arrest to running stomach and the vomiting.

17. In my experience that stretches for over ten years, all the children that I have treated did recover.

18. The other condition that I have always been successful with is "mootlwa". If a patient suffering from "mootlwa" is taken to the hospital, the Western doctor will perform a surgical operation to remove the diseased organ. We do not operate on the person.

19. A person [with "mootlwa"] will complain of chronic stomach problems and excessive coughing. Such a patient will never get better if given the hospital medicines as these will only alleviate the symptoms for a short time. The problem will come back after a while because the doctors will have failed to treat the root causes.

effective.

17. M perceives her treatment interventions as successful.

18. M identifies a condition known as "mootlwa" which she believes could best be treated by indigenous healing methods instead of the surgical procedures that are used by Western trained doctors.

19. M believes that Western medicine is not in a position to successfully treat "mootlwa" - an illness that is characterized by physical complaints like stomach pains and excessive coughing.

20. When a "mootlwa" patient comes to us the divination bones will indicate to us the nature of the problem . To locate its exact position inside the body we will make use of a live chicken which the patient will be advised to bring.

21. The chicken is going to be rubbed with some herbs and moved all over the patient's body. The patient will be instructed to "huetsa" (breathe into) the chicken before it is slaughtered. By breathing into the chicken the disease is transferred from the patient to the chicken. Once slaughtered, the chicken is immediately cut open to enable us to locate the exact location of the disease.

22. The diseased organ so identified is removed from the chicken and roasted on hot ashes. Some of the "tshidi" (burnt ashes) are then going to be added to the roasted portions. This preparation will then be suspended on needles and administered orally to the patient. The remaining portion of the chicken that is not diseased is going to be cooked and enjoyed as a meal. A portion of the "tshidi" will then be added to the soup derived from this cooked chicken and orally given to the patient. The remaining "tshidi" is given to the patient to take home and mix

20. Through the divination bones and more specialized assessment procedures, M establishes the exact location of the illness.

21. M believes that a patient's breath does transfer his problems onto a chicken that will be used during an assessment session.

22. The diseased organ extracted from the chicken is prepared and administered to the patient in various forms as an antidote.

with his soft porridge.

23. After a while, I usually receive very positive reports from such patients who will tell me that they have recovered. I also get a lot of reports from women who will have previously failed to conceive because of the "mootlwa".

24. Some women will fail to conceive because they have a lot of "diso" (rash) inside their wombs. I have treated a lot of such women with success.

25. Recently I did help such a lady who is teacher at the local primary school. Unfortunately for reasons best known to her she does not pay me.

26. I can not tell precisely why [we use needles to administer the medicines]. I learnt the skill to treat "mootlwa" from another indigenous healer in this village after I had problems with my own son who used to cough excessively a few years ago.

27. "Mootlwa" develops on the intestines of the chicken. It is very difficult to describe this condition to you. As soon as we kill the chicken, we will see the needle-like growth

23. M uses the positive feedback she gets from those she has treated as a confirmation of the effectiveness of her treatment interventions.

24. Rash is seen at times as an indication that a patient has a gynaecological problem.

25. M has to contend with the issue of nonpayment by some of her clients.

26. Her own son's illness prompts M to make a decision to acquire the skills on how to treat "mootlwa".

27. M is convinced that a patient's illness can be "read" from a chicken that is killed for the purpose of making a diagnosis.

attached to the intestines of the chicken.

28. The problem with Western medicine is its tendency to cut everything. For such a problem as I have just described to you, a Western doctor will be tempted to cut open the patient in order to remove the ailment that will have been lodged inside the body. After some time the problem will surface again.

29. Our method of treatment destroys the problem once and for all. We remove the disease so that a patient does not have to complain about the same problem again.

30. We do not operate on people's bodies. Our method is very safe because we use the chicken to establish the exact location of the illness in the patient's body. We then remove the diseased organ from the chicken and use it to treat the patient's illness. In other words, we use disease to treat disease.

31. As the chicken is run all over his body, the patient will be requested to breathe into the chicken. In so doing, the illness that is inside the patient is transferred to the chicken through the breath.

28. M questions Western surgical procedures which she feels only give symptomatic relief to a patient's problems.

29. M is convinced that her treatment interventions are much safer and more effective as compared to Western surgical methods.

30. What is seen as a diseased organ from the chicken is prepared as an antidote to counteract the disease believed to be lodged in a patient's body.

31. A patient can, through his breath, transfer internal badness and illness onto a animal.

32. It is just like in the case of "ditaola" (divination bones). Before a diagnostic session can begin, the patient will be requested to breathe into the divination bones. In so doing the patient's illness is transferred onto the bones.

33. These two methods are more or less the same in the sense that they help us to arrive at a diagnosis of the problem. There is no way the "mootlwa" will fail to be revealed in the chicken if proper procedures have been followed. For those whose "mootlwa" illness was at an advanced stage, we can also discern from the bad state of the visceral organs of the chicken.

34. [If our treatment has been successful the patient will usually] come back to say that they feel much better. Such good reports by the patients also give us the confidence and good feelings that we are doing a good job in the community.

35. However, if the patient comes back to say that the condition has not improved, you will be expected to prepare some more medicines. In this case there is no need to use another chicken. All that need to be done is to prepare the medicines and give to

32. A patient can, through his breath, transfer internal badness onto the divination bones.

33. M is convinced that the assessment procedures she uses are effective and reliable in revealing the nature and location of a disease.

34. M uses the patient's positive feedback as a yardstick to judge the effectiveness of her treatment interventions.

35. There are some patients who may take longer before their conditions can respond positively to M's treatment interventions.

the patient.

36. As I am explaining these procedures to you I am just thinking of a boy that I treated a few years ago. He was brought to me with a long history of chronic stomach problems, loss of weight, and excessive coughing. He even had to drop out of school because his condition was interfering with his studies.

37. At first I gave him some of our cough mixtures that I had prepared. This helped only for a while. After a few months the boy was brought to me again with the same problem. When I threw the bones I could see that he was suffering from "mootlwa". I then decided to request his parents to bring a live chicken that would be used to establish the exact location of the illness. Indeed the problem was located and treated.

38. After a year or so the boy's parents came back with good news. I was informed that the boy's condition had so much improved that he had even gone back to school.

36. M cites one particular case of a boy who presented with a history of stomach problems, weight loss and excessive coughing.

37. Realizing the ineffectiveness of her first treatment interventions, M decides to use specialized process of assessment to determine the exact location and nature of the illness before another treatment strategy is followed.

38. M gets positive feedback from the patient's relatives about the effectiveness of her treatment interventions.

6.3. The case of Pamosa

Pamosa does not know the exact year during which he was born. He was however told that he was born immediately after the first World War. He appeared to be in his early seventies. He reported that he grew up as a normal child till he started experiencing some pre-training symptoms. Though not sure about how old he was then, Pamosa reported that the pre-training symptoms began almost a year after he had been to circumcision which, in the North Sotho culture usually occurs when one is a teenager. Pamosa related his becoming a "ngaka" to the death of his grandfather who was also a "ngaka". In terms of family, Pamosa got married to his maternal uncle's daughter. He has seven children (one son and six daughters) who are now all married. All his daughters have moved out of the family. At the time of this study, Pamosa was staying with his wife, his son (and his family) and two of his many patients. He described his relationship with his wife and children as good.

A	NATURAL MEANING UNITS	B	CENTRAL THEMES
1.	Before I started practising as an indigenous healer, I became seriously ill and spent twelve months in bed. During that time I could not eat or talk to anybody. My illness was so serious that even my relatives thought I was going to die. All the medicines that were given to me could not help.	1.	A long illness precedes P's training as an indigenous healer.
2.	One day I had a dream that ultimately changed my life. In my sleep, I saw my grandfather approaching me with a wooden plate in his right hand. He was accompanied by another old man who I did not know. This other man had a very big knife in his hand. The two men just stood beside me	2.	Lying on his sick bed, cut off from the rest of the world, and in great despair, P experiences an ancestral dream that has great significance to him later in life.

without saying a word. After a while this other man started wielding the knife as if he was going to stab me.

3. I got so scared that I screamed at the top of my voice. When my parents came into my bedroom, they found me seated on my sleeping mat. For the first time after a very long time I started talking. Everybody at home was surprised.

4. From that day onwards I started having a lot of dreams in which my grandfather would show me different types of divination bones and medicines that I was supposed to use as an indigenous healer.

5. This went on until I became proficient in the use of the divination bones and medicines. I was never trained by anyone. My ancestors guided me all the way until I became an indigenous healer.

6. In our practice we first have to establish the nature of a patient's problem through the divination bones.

7. Once the diagnosis has been made, we will move to the next step of establishing the appropriate form of intervention. This

3. Despite its unpleasant aspects, P's dream helps him to start communicating with other family members - something he had not done for a very long time.

4. P begins to accept his dreams and to positively interpret them as a vehicle through which to become an indigenous healer.

5. P sees himself as an indigenous healer whose skills were acquired only through the guidance of the spiritual beings.

6. Before P begins to treat his patient, he makes use of some assessment procedures to establish the nature of the problem.

7. The same assessment procedures are again used to determine the kind of treatment programme that will be

treatment programme is arrived at also through the divination bones. The bones tell us exactly what kind of treatment will help the patient. We do not just use the medicines haphazardly. We always have to make sure that we have been guided by the bones.

8. Just to give you an example. If you come to us complaining of painful legs and joints, we do not guess the type of treatment that should be appropriate for your condition.

9. The first thing we have to do is to establish the nature of your problem through the divination bones. The treatment that will be given to you will depend on the nature of your problem as revealed by the divination bones. Even if the medicine that should be given requires mixing seven or eight herbs, we have to do just that to make sure that you get better.

10. The various herbs that will have been collected are then chopped into small pieces. These pieces are going to be burnt on a "leeta" (broken piece of clay pot). Whilst the herbs are burning, we will place the "leeta" next to your head and pull a blanket over your head so that you can inhale the smoke.

appropriate for the problem that is presented.

8. Developing a treatment plan is a systematic process that has no room for guess work.

9. With a primary goal being to restore good health, P follows all the necessary steps when dealing with a patient's problems.

10. Medication consists of several ingredients which are burnt together and inhaled to bring about the desired effect.

11. At the end of this process, that is when we are satisfied that you have "orela" (inhaled), we will grind the burnt herbs into a "tshidi" (ground ash). We will "hlabela" (make small incisions) on your joints. These incisions should be deep enough to cause bleeding. As soon as the blood begins to show, we dip the "tshidi" in fat derived from a pig and rub this mixture into the incisions.

12. Pig fat has a neutralizing effect if your condition has been inflicted by witches. It has the capacity to stop evil forces if used properly. You may have heard about Makhwatla, a man who used to move around in this area a few years ago. This fellow used to attract a lot of attention around because of the magical activities that he performed. What was however interesting was that he did not allow anyone who had applied pig fat on his body to be in the audience during his magical performances. The fat would neutralize his magic.

13. Usually when your illness is caused by witches, we mix the herbs with "tshidi" called "maloimaleko". This concoction is going to be left overnight in a bowl full of water. The following morning we will sprinkle this preparation all over your body.

11. Physical treatment involving intravenous application of medicines is found to be appropriate for some illnesses.

12. Pig fat is believed to have the effect of countering those conditions that may be brought about by evil doers.

13. Time is considered as another factor in some treatment activities.

After some time you will certainly get better.

14. We are always guided by our ancestors in the practice. Without guidance by the ancestors, an indigenous healer will be like a wandering stranger whose path will lead into a cul de sac. Such a "ngaka" will not know the right treatment for his patients. We have a popular saying in Northern Sotho which goes like: "Malome a tsela ke molomo" [A wondering stranger's best companion is his mouth]. What I am saying here resembles what is expected of us as indigenous healers.

15. We first have to throw the divination bones to establish the nature of our patient's condition. We do not rely on the opinions of others for appropriate treatment. Often such opinions will contradict the kind of treatment that will be indicated by the divination bones.

16. Unfortunately some indigenous healers tend to bypass this essential step of divination [throwing of the bones]. This is very dangerous as they will usually arrive at a wrong treatment. The best way always is to rely on the divination bones.

14. P is convinced that he is constantly in touch with the spiritual beings who guide him in his practice.

15. Through a process of assessment, the nature of a patient's condition is established before a treatment programme is considered.

16. Failure to do a proper assessment may be detrimental to a patient's health.

17. At times a patient may complain of a headache and consult a Western medical doctor. Usually such a patient will be given a Panado or a Compral to relieve the headache. The problem with this type of treatment is that it is symptomatic as it only relieves the headache temporarily. Our solution to headaches is meant to be permanent.

18. Let me explain to you how we treat a person with headaches. When such a patient consults, we use "letlobo" (snake skin). This is going to be ground and mixed with other types of herbs which are chopped and placed in a "leeta". This concoction is then placed next to the patient to "orela".

19. The residue derived from these burnt herbs is ground into "tshidi" which is applied onto a thin rope that is going to be tied around the patient's head. After a few days the patient will be instructed to go to the bush and untie the rope from his head. This is then tied onto a tree. After doing that the patient has to come back without looking back. The patient will get better because his illness has been transferred to the tree in the bush. This is a permanent cure.

17. P feels that his treatment procedures for headaches offer permanent solutions when compared to Western healing methods which he perceives as only treating the symptoms.

18. To offer a permanent cure for headaches, some components derived from animals and plants are mixed and administered to bring the desired healing effect.

19. A patient is instructed to strictly follow a series of steps which are perceived to lead to healing.

20. The patient will get better because of the intervention of ancestors or God. In some cases it depends on your expectations as a patient. If you trust me, you will believe that my medicines are going to make you feel better. In other words, if you come to me with high hopes the chances are good that you will recover. At the end of the treatment when you feel much better you will praise me for being a good indigenous healer. The fact that you got better when you were in my care will convince you of my credentials as a good indigenous healer.

21. Remember, we always have to establish the exact nature of the patient's problem through the divination bones. This also applies to the nature of a treatment programme that has to be followed.

22. In on the first throw the bones do not give us a good diagnostic picture we always have to keep on trying.

23. An indigenous healer who follows these guidelines properly will never go wrong. His patients will always recover after only a short period of time. This will equally apply in the case of those patients who are

20. Improvement on the part of the patient is seen to come about as a result of intervention from God and some patient variables like high expectation and positive regard of the indigenous healer.

21. Proper assessment procedures are always followed to establish the nature of a patients problems and an appropriate treatment plan.

22. At times it may take a very intensive consultation session with the patient before a clear assessment of the patient's problem is made.

23. There is always a need for the indigenous healer to follow proper assessment and treatment procedures.

expected to stay with us to receive treatment. With proper treatment, we will cut down the length of time that such patients will spend with us.

24. After a few days they will usually tell us that they are feeling much better and that they are ready to go back home.

25. Another important thing about our inpatients is that we give them enough time to rest while at the same time they receive regular doses of medication. It is wrong to give a patient a lot of work to do. After all, he is going to pay you for your services. Why should you overwork him? The ancestors will not be pleased with you having to ill-treat your patients.

26. As soon as we are convinced that the patient is much better, we will invite the relatives of the patient to come and make their own assessment. They will talk to him and communicate their impressions to me.

27. If they are satisfied, they will pay me for the services. I do not take their money if I fail to cure the patient. If the patient gets better whilst he is in my care, he will always come back whenever he gets sick. If such a

24. Treatment is considered effective when patients say they feel much better.

25. Apart from the medical treatment given, relaxation is also considered an appropriate form of treatment for inpatients.

26. Towards the end of a treatment programme, a patient's relatives are invited to make their own assessment on whether or not the patient has improved.

27. By showing genuine interest in the patient's health rather than the remuneration to be obtained, P earns the respect and trust of those he helps.

patient comes back within a year after discharge, he will not have to pay for the divination session. I will expect the payment only for the treatment that I will give. On the other hand if such a patient comes to me a year after I will have treated him for an illness, I will expect payment for both the divination session and the medicines.

28. Another important thing to note here is that we do not use a patient's money immediately it is given to us as payment. Those who get tempted and use the money immediately will anger the ancestors. As soon as I am paid I need to inform the ancestors about this payment and thank them for the referral.

29. If I fail to thank them [for the patient's payment] they will be so angered that they may decide to block the practice and bar any patients from coming to me. In other words, I will have closed the gate and thus stopped the flow of patients.

30. If a woman comes to us complaining about infertility, there is only one effective type of treatment. We mix some herbs and give these to the patient to "orela". The "tshidi" derived from these burnt herbs is

28. Patients are believed to be referred by the spiritual beings hence P will show appreciation to them (ancestors) whenever he is remunerated for his services.

29. A slump in practice is at times interpreted as an indication of ancestral anger.

30. P prescribes a treatment programme (strictly to be followed by a patient) for what he perceives as infertility. Treatment is considered effective when the patient sees tangible results by falling pregnant.

going to be given to her to take home. She will be advised to take this "tshidi" with her soft porridge every morning. After a fairly short time, the patient will usually come back to us smiling to say that she is expectant.

31. Sometimes we see children who suffer from "bolwetsi bja ditshwene" (monkey disease). Such a child will tend to be shy and very withdrawn to maintain eye contact. These symptoms will show that the child is having "bolwetsi bja ditshwene". We will prepare some herbs and give to the child to "orela". Usually it will take only a day or two for such a child to recover.

32. Some children may present with what we call "metsho". Such children will tend to be fidgety and self destructive. Other symptoms related to "metsho" are a high temperature and intermittent crying spells. Children with this problem respond favourably to oral medication and treatment that is given through "go orela". Usually such a child will only take two to three days to recover if given proper treatment.

33. We will usually notice some improvement from the way the child will

31. P describes "bolwetsi bja ditshwene" as a condition of ill health that is characterised by poor eye contact and shyness.

32. P identifies another childhood illness (known as "metsho") which appears to respond favourably and quickly to his treatment procedures.

33. Apart from his own observations, P gets

start to behave after treatment. If a child has been suffering from "metsho", for example, we will see such a child becoming more contained and not running around. The child will participate meaningfully in play activities. Often the parents will come to us and say that the child is much better.

34. Our patients are very important to us because they have been sent by our ancestors. We have to always treat them very well. If they are staying with us we will treat them like our family members. This means that if for some reason the patient misbehaves while staying with us, we will discipline them in much the same as we would to a family member. If the patient continues to misbehave, we will certainly start suspecting his mental condition.

35. We always have to give the right dose. Even when the patient takes medication home, we will give instructions on appropriate quantities that need to be taken. It is obviously dangerous to take an overdose as this will tend to complicate the patient's condition. Taking an overdose is like consuming more alcohol than your body can take. To get reasonably intoxicated, you only need to take enough alcohol that your

feedback from the parents of sick child in order to determine the effectiveness of his treatment procedures.

34. Whilst seeing his patients as special in the sense that they are referrals by the spiritual beings, P relates to them as he does to members of his own family.

35. P is aware of the dangers of overdose hence he instructs his patients to follow instructions strictly when taking medication.

system will be capable to handle. A similar situation obtains in the case of medication that we give to our patients.

36. In the case where an indigenous healer does not follow proper instructions [the doses may be harmful]. If proper doses are given as guided by the divination bones, there is no way such a situation will arise. One important advice we always give to our patients is to avoid alcohol when they are on our medication. Mixing medicine and alcohol can be dangerous.

37. I would like to tell you about one disease that I have always found fascinating to treat. This is called "vaal siek" or "bolwetsi bja go wa" (seizures). There are many treatment methods for this kind of disease.

38. After establishing the nature of the problem through the use of the divination bones, we will advise the patient to bring along a goat. We use the goat to establish the exact area in the body where the disease is located. We run the goat over the patient's body and request him to breathe into its mouth.

36. A treatment programme should always be informed by a clear assessment of the problem.

37. P offers to talk about what he regards as "bolwetsi bja go wa" or "vaal siek" (epilepsy).

38. Through his breath, a patient is believed to transfer his [epileptic] condition or internal disease onto a goat.

39. The goat will then be killed and cut open to see what is going on in its viscera. The cause of "vaal siek" is excessive blood in the patient's system thus leading to congested vessels. Once this happens, the patient collapses.

40. The excessive blood will be clearly visible inside the goat. This congested blood chokes the veins and lead to intermittent seizures. It is a very dangerous disease because if the patient is alone at the time of the seizure, he may die.

41. In order to treat our patient we will remove the diseased organ in the goat and mix this with some herbs that will have been chopped into small pieces. This concoction will be given to the patient to "orela" (inhale).

42. The "tshidi" (ground ash) derived from these burnt herbs is applied to the patient's body through "go hlabela" (incision). The remaining "tshidi" is given to the patient to take home. This will have to be taken regularly with soft porridge.

43. The patient [with "vaal siek"] will be advised to avoid salt in his food for a period

39. P is convinced that the patient's condition can be revealed in the goat. He offers an explanation of a physiological process that leads to seizures.

40. If left alone a person with "bolwetsi bja go wa" may die should he get the seizures.

41. P believes that the diseased organ extracted from the goat can be used as an antidote to counteract the disease in the patient's body.

42. Medication which is prepared by combining the diseased organ and some herbs is administered to the patient orally and intravenously.

43. The patient is advised to avoid salty food as this is seen to interfere with the

of six to twelve months. This will give the patient's body enough time to heal. If there is a lot of salt in the patient's body, his illness will take too long to heal.

44. It is also very important to advise the patient to avoid red meat. If these instructions are not followed, it will be extremely difficult for the patient to improve. If on the other hand these instructions are followed, the patient will improve quickly. Once we are convinced that the seizures are gone, the patient will be allowed to take salty food and red meat again.

45. The divination bones are derived from different types of animals. We have in our collection bones of lions, monkeys, wild bucks etc. We also have in our collection various types of shells that are obtained from the sea.

46. During training, the budding indigenous healer will be visited by the ancestors who will indicate the type of bones and shells that need to be assembled to complete a set of divination bones.

pharmacological activity of the medicines.

44. Patients are also advised not to take red meat as this is seen to counteract the pharmacological activity of the medicines.

45. The items that are assembled to make up a divination set are varied and believed to be those desired by the guiding ancestors.

46. The process of becoming an indigenous healer is guided by the spiritual beings who will also decide about the types of items that should constitute a divination set.

47. There are many ways in which the bones are interpreted. Sometimes we may say the bones are "asleep" if they do not give us an indication of the problem even after repeated attempts to throw them. At times the bones are said to be "awake" because they indicate to us the nature of the problem and treatment programme without having to try many times.

48. All these different "moods" of the divination bones are dictated by the ancestors. Usually the bones that are "asleep" are a reflection of ancestral displeasure.

49. The ancestors guide us all the way. They are like that careful passenger who will hasten to advise a driver who is leading a car into a ditch. If the driver does not heed the advice, a caring passenger will try to control the brakes and steering wheel to avoid an accident. The ancestors are also acting like a caring passenger. If after repeated warnings one does not listen, the ancestors will block his practice and no patients will come any longer.

50. The ancestors are very powerful. They derive their power from God. If their orders

47. The divination bones are animated and thus interpreted in terms of whether they are "asleep" or "awake" at a given time.

48. No meaningful assessment of the problem can be made through the divination bones that are "asleep". This unfavourable fall of the bones is usually attributed to the displeasure of the spiritual beings.

49. P is convinced about the omnipresence and omnipotence of the spiritual beings who guide him in his practice.

50. A harmonious relationship has to be maintained between the spiritual world

are disobeyed, they get angry and decide to punish the offending individual by making him sick.

51. When [a person who will have disobeyed ancestors] comes to us for help, the divination bones will indicate to us that the ancestors have been angered and that certain rituals need to be performed in order to re-establish the link between one's family and the spiritual world. The ancestors will further require such an individual to wear a specially made wrist or neck band which serves as a protective device.

52. Just to give you an example here. There is a lady who recently came here because she had panic attacks and repeated episodes of sleeplessness. The divination bones indicated that the ancestors are angry with her family for having failed to observe certain rituals. Her treatment was two fold.

53. Firstly, some herbs were given to her to take orally. Secondly, her family was required to perform certain rituals during which an ox was slaughtered and sacrificed to the ancestors. After she had taken all her medications and all the rituals had been performed, her relatives came to thank me

(occupied by God and ancestors) and the living for the sake of good health.

51. A harmonious relationship between angered ancestors and the living will be re-established through the performance of some rituals and the use of certain protective devices like wrist and neck bands.

52. Panic attacks and sleeplessness are interpreted as indications of an underlying disharmonious relationship between a patient and the spiritual forces.

53. For these symptoms P prescribes some medicines and performance of rituals leading to positive outcomes.

for the improvement that was noticed.

54. "Malopo" is some form of possession by the spirits of one's forefathers. The spirits will expect those possessed to perform the "malopo" dance. "Malopo" will show in the form of an illness which will require appropriate treatment programme that includes the performance of "malopo" dance.

55. There are those who may pick up "malopo" illness because there is history of this experience in their families. If on the other hand one's possession is an indication of a call to become an indigenous healer, such an individual will be expected to go through the training programme that will involve acquisition of diagnostic and treatment skills.

56. During the possessed state, the person will cry and his body will shake uncontrollably. Crying is an indication that one feels pain. During the possessed state, one will not know what is going on around him. It is as if such a person is dreaming. It is only after regaining full senses that he will be told about everything that took place during the possessed state.

54. The "malopo" experience is manifested in the form of an illness (brought about by the spiritual beings) which is ameliorated by performing the "malopo" dance.

55. "Malopo" may either be a familial illness or an indication that one is called to become an indigenous healer. In both cases "malopo" dance is performed.

56. A person possessed by "malopo" enters a dream-like altered state of consciousness with no recollection of the events when full consciousness is regained.

57. It is like in the case of "ditlajane" which is caused by witches who have the ability to transport a person, whilst asleep, to a secret rendezvous in a far away place. Such a victim will be physically abused whilst transported. The witches will only return their victim early in the morning before sunrise. On waking up, such an abused person will complain of general body pains.

58. In such cases [of ditlajane] we will prescribe medicines that will need to be taken through "go orela". A portion of this medication will be given as a nasal inhalant. This is intended to open the victim's mind to recollect all that will have taken place during the night in question.

59. Another important thing to do [for a "ditlajane" patient] will be to visit the victim's family in order to "aga motse" (protect the homestead). What has happened here is that the witches have turned the victim's home into their playground. Unless the homestead is strengthened, these evil people will keep on coming.

60. There is some kind of connection between ["go aga motse" and the neck bands] because they all have a protective

57. P likens the dream-like state of "malopo" to what he calls "ditlajane" - a condition that is perceived to be inflicted on a victim by those harbouring evil intentions.

58. Apart from treating the physical complaints, the medicine administered on the "ditlajane" patient is also seen to facilitate recall of events during the dream-like state.

59. Whilst the patient's health is restored, P will also carry out some treatment and preventive programmes that are aimed at the individual's total environment.

60. A feeling of security is achieved by those who have themselves and their homesteads protected.

64. When a patient [with "mafofonyane"] is brought to us, we will start by establishing the exact nature of the problem through the divination bones. Once this has been done, we will throw the bones again to establish the treatment programme that will be appropriate for that patient. Usually we will give the patient some medicines to "orela". Some of the medicines will be applied through "go hlabela" which serves a protective function.

65. As soon as the patient improves, we will arrange with the patient's family to have him taken home. It is important to have the patient's home protected before he is taken back. If this is not done the patient will relapse. So we need to be sure that the patient's home environment is safe and well protected before he is taken back.

64. Through his assessment procedures, P establishes the nature of a patient's problem. Once the problem is established, treatment and preventive programmes are planned.

65. Apart from treating the "mafofonyane" illness, P follows some elaborate procedures that are aimed at the patient's total environment.

6.4. The case of Rammalo

Rammalo stays in Tickeyline - a village that is situated in the area that is under Kgoshi Mogoboya. At the time when the interviews were conducted, Rammalo had six patients staying with him. Almost all of these patients were observed to be physically well as each one of them was assigned some responsibility in the homestead. In terms of family, Rammalo stays with his

three wives and ten children. Asked about why he has more than one wife, he indicated that as an indigenous healer it would be difficult for him to have only one wife as she would not be in a position to attend to all the household activities. Rammalo is practising as an indigenous healer full time. Every year Rammalo goes to stay for a few months in Johannesburg where he also sees many patients. He stated that he makes a lot of money when he consults patients in Johannesburg since most of them are working and prepared to pay.

A. NATURAL MEANING UNITS

1. In fact I started training as an indigenous healer in 1965. I was still very young at that time. Before I became an indigenous healer I fell ill. My family tried all forms of treatment without success. I was taken to several Western doctors but these could not help.

2. At last I was initiated into the "malopo" dance. This proved to be the best treatment for my problems. My ancestors responded and made their intentions known. They did indicate that I should become an indigenous healer.

3. I was trained by my brother who was also an indigenous healer. He taught me all the skills like divination and how to use the various herbs. He took me through all the stages of "go thwasa" (training) before I ultimately graduated as an indigenous

B. CENTRAL THEMES

1. What is seen as an illness prompts R's relatives to consult Western health professionals who do not succeed in relieving him of his distress.

2. The illness is redefined as a call by ancestors who would like to see R becoming an indigenous healer. Through "malopo" dance, R is made to feel better.

3. R is guided by his brother (also an indigenous healer) through the period of apprenticeship until he qualifies as an indigenous healer.

healer.

4. To train as an indigenous healer one has to be ill first and also one has to go through the "malopo" experience. There are others who will not go through this process. These are people who come from families which have indigenous healers. Such individuals will be taught the skills of indigenous healing by their relatives. Because they have not gone through the usual channels of ancestral guidance we call them "dingaka tshupsa" (those who have been guided by others).

5. The difference between "ngaka" and "ngaka tshupsa" lies in the fact that the latter will only treat a limited number of conditions unlike a "ngaka" who will usually have a broad client base. Unlike a "ngaka tshupsa", a "ngaka" will be visited at night and guided by ancestors on matters like where to get herbs to treat patients. The ancestors will give an indication of how these herbs need to be mixed and what quantities have to be administered. These instructions need to be followed strictly.

6. As indigenous healers, we always have to rely on the ancestors because they are the

4. R distinguishes between two categories of indigenous healers, namely a "ngaka" and "ngaka tshupsa".

5. In addition to a broad scope of practice, a "ngaka" (compared to "ngaka tshupsa") is in constant touch with the spiritual beings who are seen to be giving instructions on various issues related to the practice.

6. R sees himself as an authentic indigenous healer who is constantly guided by the

ones to give us constant guidance. An indigenous healer who follows these guidelines as given by the ancestors will always be successful.

7. For six months I was bed-ridden and all Western medicines could not help me. This was however a relatively short time as compared to many other indigenous healers who may be ill for many years.

8. As soon as I completed my training, my brother started delegating some duties to me. At times he would, at the behest of patients, be away from home for a very long period of time. During these days of his absence, I would run his practice. When he came back home, he would be impressed with my work. Often I would give him a lot of money that I would have collected from the patients. So we worked in a partnership for many years. My brother was a senior partner. I only started practising on my own since 1980.

9. I see all sorts of clients including the mentally disturbed, the epileptics, the unemployed who want medicines to help them secure jobs, people with sexually transmitted diseases, those who are in search

spiritual beings.

7. The pre-training symptoms persisted for six months - a relatively short time in comparison to that of other indigenous healers.

8. On completion of his training as an indigenous healer, R enters into a partnership with his brother - an association that helps him to gain experience and confidence before he sets up his own practice.

9. In R's view, an indigenous healer's scope of practice is broader than that of a Western doctor. He believes he has the necessary skills to deal with the various complaints presented to him by the clients.

of good fortunes and those who want their homesteads strengthened. The list is endless. If I strengthen your homestead, you will no longer fear witches, lightning, and all sorts of problems. Our work covers a lot of areas compared to a Western doctor who will only work in the hospital.

10. When a patient comes here, the first thing he would like to know is the diagnosis. After we will have exchanged greetings, I will invite the patient together with his relatives into "ntlo ya badimo" (ancestral house or consulting room). I will throw the divination bones which will give me a complete picture of the patient's problems including those of the other family members. I will communicate all these impressions to the family members attending the divination session.

11. If [the patient's relatives] concur with my diagnostic impressions, I will require them to give me an advance payment of R50 which is known as "phuthulla moraba". This will give me an indication of whether or not these people are serious. The outstanding balance will only be settled once the patient has improved. The settlement amount asked will depend on the nature of the patient's

10. After a normal social chat to break the ice, R invites his patient (and relatives) into what is perceived as ancestor protected consulting rooms. Through his assessment procedures, R establishes the nature of the problem and communicate his impressions to the consultees.

11. The payment of an initial fee by the consultees is taken to be indicative of a high level of commitment to treatment by the patient and his relatives.

problems.

12. It is always easy for us to tell if a patient has improved. If a patient comes here unable to walk, I will say he has improved only when I see him walking unaided. I have a patient at the moment who came almost two months ago. When she arrived here her condition was very bad. She was very weak as she had not been eating for a very long time. Right now she is much better. I can even arrange for you to see her. I am about to call her relatives to come and assess her condition. If they are satisfied, she will be discharged.

13. You see if the relatives come and tell me that they are satisfied with the progress that the patient will have made, I tell them to arrange to welcome the patient back home. I will expect them to pay me only if they are satisfied with my services.

14. The medicines that we give to the patients make them better. All the medicines that we give to the patients have to be mixed with what we call "tshidi ya badimo". This "tshidi" (ground ash) must always be added regardless of whether the medicines are taken orally, through a steam bath or otherwise.

12. Through observation, R establishes whether or not a patient has benefited from treatment. He gives an example of a patient who has improved whilst in his care.

13. The relatives will communicate their own impressions about treatment progress before the patient is discharged.

14. R is convinced about the potency of his medicines which may be administered to the patient in various ways.

15. ["Tshidi ya badimo"] is a very important component of our medical preparations. Every patient receiving my medication must have his medicines mixed with this "tshidi". Even if the patient is epileptic or mentally disturbed, this "tshidi" is very important. Without it there is no way a patient will get better.

16. [The length of time it takes for an average patient to get better] depends on the nature of the illness, it may take a week, two weeks, or longer. If, for example, a patient is brought here in a critical condition and unable to walk, it will usually take longer. I will normally prescribe a course of treatment that will comprise of different types of medicine and rituals.

17. Usually after two weeks we will begin to notice progress. The patient will also normally indicate to us that he feels much better.

18. To some extent [the patient's expectations do affect his chances of recovery]. What is more important is for his ancestors to wish to see him recovering. In other words, if his ancestors are not satisfied, the patient will not improve. Both

15. R believes that "tshidi ya badimo" has some antidotal properties - hence it is added to all medicines.

16. What R perceives as critical conditions take longer to improve.

17. To assess the outcomes of treatment, R relies on his own clinical observations and the patient's own subjective report.

18. A combination of several factors, which include the patient's expectations, the indigenous healer's intervention strategies and blessings from the spiritual world are all seen as important variables that lead to effectiveness of treatment programmes.

my ancestors and the patient's ancestors must share a wish to see him improving. My interventions will not be effective if the patient's ancestors are not happy. There will have to be some kind of dialogue between my ancestors and those of the patient and this will facilitate recovery on the part of the patient.

19. As soon as a patient arrives here we have to communicate with the ancestors. We throw the bones in order to discover the nature of the problem.

20. Once the problem has been identified, we ask for a "phuthulla moraba" (initial fee). This is a fee that is paid by the patient before we can start with a treatment programme. It also gives us an indication of whether or not the patient and his relatives will be committed to the treatment programme which at times may take longer than they think.

21. As soon as the "phuthulla moraba" fee is paid, I will perform a small ritual through which I request my ancestors to help me make the patient feel better. This is a very crucial step because it is ultimately the ancestors who bring about improvement on

19. Whilst maintaining constant communication with the spiritual world, R uses his assessment procedures to establish the nature of the patient's condition.

20. As soon as a patient arrives, R informs the spiritual beings and immediately uses some assessment procedures to establish the nature of the consultee's problems.

21. Before embarking on a treatment programme, R communicates with the spiritual beings whom he believes are instrumental in bringing about positive change on the part of the client.

the part of the patient. In other words, there is no way you can successfully treat a patient without first communicating with the ancestors.

22. I see a wide range of patients. I do however deal mainly with those patients who are mentally disturbed. I also see a lot of people who suffer from seizures. There are many others who come to see me because they want more luck.

23. Still there are those who want to have their homesteads protected because they may complain about strange sounds that haunt them in their sleep. A lot of the clients I see in Johannesburg are usually those who want to have their homesteads protected. That is why I have been to all corners of this country because I have to go to my clients' homes in order to perform these protective rituals.

24. After I will have protected their homestead, these people often come to thank me for the job well done. Usually people who want to have their homesteads protected against evil forces will complain of lack of sleep, fear, and that their children cry at night. The medicines that I prepare

22. R sees a wide range of clients the majority of who he regards as mentally ill.

23. R believes that some of his treatment procedures have the capacity to rid the consultee's home environment of current and potential threats.

24. R is convinced that his treatment procedures are effective in the sense that they restore good health to the entire family of the consultee.

help to chase away all these evil forces lurking in their homesteads.

25. We use a variety of herbs. Of course we have to add "tshidi ya badimo" to all these preparations. The other ingredients include barks, leaves, and roots of tall trees, bits of soil from the mountains, sand and water from the sea. All these ingredients are mixed and spiced with goat blood. This mixture is going to be sprayed all over the homestead.

26. If you look at the tall trees you see them always blowing to the wind. As they blow fresh air is distributed all over. The extracts from these tall trees are going to help drive away all the evil forces and bring healthy conditions in the homestead.

27. We can not use ordinary sand or water [in our medicines]. I am sure you have seen how strong a sea is. Everything that falls into the sea gets carried to far away places. By adding sea water to the ingredients, we are trying to clear the homestead of all the impurities that have been brought by the evil forces. Should we fail to secure sea water we can also use water obtained from the waterfalls. Sea water is always our first preference.

25. Various herbs are mixed with what is perceived as an antidotal preparation ("tshidi ya badimo") to bring about the desired effect.

26. Medicines derived from tall trees are believed to "blow away" the illness.

27. Sea water or water obtained from waterfalls is taken to have a purifying effect on the patient's home.

28. [The type of blood we add to the medicines] depends on the nature of the problem. If the problem is not so serious, we may use a fowl instead. This will of course depend on what the divination bones tell us. If we find that the people in the homestead are also having "senyama" (bad luck), we will also prescribe some medicines that are going to be used to cleanse their bodies.

29. There are two or three types of "senyama". A man may get "senyama" through sexual contact with a woman who has aborted or is menstruating. Such a woman is seen to be polluted. Any sexual contact with her will bring "senyama". Such a woman is also dangerous if she comes into contact with children.

30. Another type of "senyama" is caused by witchcraft. Some people with evil intentions may invoke "senyama" to strike a young man who is going to Johannesburg to look for a job. Even after repeated attempts to secure a job such a young man will not succeed. The witches are responsible for his misfortunes. It is only after we will have "hlapisa" (cleansed) him with the appropriate medicines that he will be in a position to get a job.

28. The assessment procedures will indicate to R the various ingredients that have to be put together to complete a treatment programme.

29. Heedless sexual conduct is perceived to be detrimental not only to the health of those involved, but also that of innocent children.

30. Jealousy and other evil intentions are believed to drive some people to manipulate mystical forces which bring harm to those they envy or dislike.

31. The third source of "senyama" has to do with our funeral customs. If you attend a funeral you will realize that there is always a basin at the entrance to the deceased's home. On our return from the cemetery we have to wash our hands in the basin so as to remove the "senyama" that is associated with the corpse and places like a cemetery.

32. If this ritual is not observed you risk contaminating your family, particularly the children. You have to always wash your hands before you go back to your place. In some Christian families there is a tendency to spray all the people entering the deceased's home with holy water. At times this does not work.

33. Still talking about funeral customs, if you eat food prepared at the funeral without washing your hands first, your stomach will swell. This will indicate to us that you have "senyama".

34. For me as an indigenous healer it is even more important to wash my hands before I leave the deceased's home. Failure to do so will be disastrous as this will contaminate my consulting rooms, the divination bones, and the medicines. This will lead to a

31. Non-observance of funeral rites and customs is a third causal factor in "senyama". Washing hands after returning from a cemetery is believed to remove "senyama".

32. "Senyama" caused by non-observance of funeral customs is believed to have a contagious effect in the sense that the victim's family, including children, will get contaminated if the condition is not treated before it spreads.

33. Non-observance of some hygienic practices (like washing hands at a funeral before having a meal) is seen to lead to "senyama".

34. A slump in the flow of patients may be attributed to contamination by "senyama" which is caused by failure to observe some funeral rites.

situation where patients will stop coming. I will have blocked my practice by being reckless. You need to make sure that your hands are washed.

35. In the case of "malopo" one is troubled by people who have passed away, that is, grandparents and great grandparents. By beating the drums during the "malopo" sessions we are inviting the ancestors to come closer.

36. Apart from the drumming, we may also invite the ancestors by administering some medicines to the possessed. With repeated drumming, hand clapping, and song, the possessed will start shaking and crying.

37. At this stage we will know that the ancestors have come closer. We will ask the ancestors to communicate their needs and intentions to us through the possessed person. They will tell us as to what should be done. They will also indicate to us the type of treatment that should be given to the possessed. If the ancestors indicate to us that they would like to have a goat or sheep as a sacrifice, we have to make sure that such an animal is made available. Failure to do so will only complicate the problems. If

35. "Malopo" provides an opportunity during which a spiritual presence can be invoked through rhythmic drumming, hand clapping, and song.

36. Some medicines may also be used to invoke the spiritual beings who will show themselves through the possessed individual.

37. Through the possessed individual, the spiritual beings are believed to communicate with R who will interpret their messages and advise the patient to carry out their instructions.

however we satisfy the ancestors by doing everything they want, the person who is possessed will get better.

38. This shaking [by a "malopo" person] is caused by the ancestral spirits. They have come to settle in the person's body. In other words the person is no longer in his full senses. It is the ancestors who have taken over his body. All the utterances will come from the ancestors even if it will be the possessed person who expresses them.

39. It is only when the ancestors leave the body that a person so possessed will regain full senses. During the "malopo" experience it is like the body is magnetized or frozen. The person will not recollect what happened during the possessed state. It is only when we give a full explanation of the events that he will know what happened. All the instructions that will have been given by the ancestors during the "malopo" episode will be followed.

40. Sometimes it may happen that the possession has got nothing to do with one ultimately becoming an indigenous healer. It may be that the ancestors only want this person to perform the "malopo" dance. Once

38. R interprets what seems to be a patient's altered state of consciousness as a reflection of ancestral presence.

39. After a "malopo" person will have regained consciousness, he will not be able to recollect the events experienced during the possessed state.

40. Not all people who are possessed by "malopo" end up being indigenous healers.

this has been done, the person will feel better.

41. If on the other hand the "malopo" person is chosen to become an indigenous healer, we have to do much more than just the "malopo" dance.

42. After a diagnosis [of "malopo" condition] will have been made, there will be a series of steps that will be followed. Because the individual concerned will also present with various complaints, these have to be treated.

43. Whilst giving treatment to the patient, we will also start training him to become an indigenous healer. In this regard we will introduce him to all the divination procedures and medical knowledge.

44. Apart from these [treatment] programmes that will be in place, the patient's ancestors will also be communicating with him regularly. They will come when he is asleep to show him where to find some medicines and how these need to be prepared. They will also indicate to the "thwasa" person (trainee healer) what kinds of paraphernalia he should have. Some

41. Those destined to become indigenous healers will be required to go through elaborate procedures before they qualify.

42. Apart from being offered apprenticeship, the "malopo" person is also given treatment for the illness component of the "malopo" experience.

43. R does not only offer treatment, but he also imparts assessment and treatment skills to a budding indigenous healer.

44. The skills imparted by R are supplemented by the spiritual beings who are believed to "visit" and "guide" the trainee healer during the "go thwasa" period.

animal skins and other types of paraphernalia may have to be obtained.

45. Once all the steps have been followed, arrangements will be made to take the trainee back home. The trainee's relatives will organize a big party that will take place on a Friday up to a Sunday when we will leave the trainee at his place. This will mean that he is ready to start practising as an indigenous healer.

46. We [take our trainee back home] because [his] ancestors have to be taken back to where they belong. If we do not take the graduate back home, his ancestors will remain at my place and this will not be good for the practice of the new indigenous healer. We make arrangements with his family to organize food and drinks for the big take home ceremony which will be attended by the family and members of the community. It really becomes a big occasion because we will start celebrating on a Friday up to a Sunday when we will come back.

47. For the entire weekend of the celebration, the graduate indigenous healer will be busy as many people will consult him with their problems. He has to prove to

45. Through a ceremony which is also attended by R, the newly graduated indigenous healer is welcomed by his family and members of the community.

46. R indicates that the newly qualified "ngaka", like all indigenous healers, will need to be constantly guided by the spiritual forces.

47. Apart from its social significance, the take home ceremony provides a platform for the newly qualified indigenous healer to put his newly acquired skills to test by

them that he is a good indigenous healer. If these people are satisfied, they will continue consulting him after we will have left his place.

48. Usually on the Saturday of the ceremony, we will deliberately hide something and instruct the newly qualified indigenous healer to sniff out its whereabouts. His search will begin in full view of all the people attending the ceremony. If he discovers the whereabouts of the hidden item, we will be convinced that he is going to be a good indigenous healer. Even the people attending the function will be impressed and will thus want to bring their problems to him.

49. The new graduate will be guided by the ancestors to discover where the hidden object is. This will convince us further that the graduate is indeed guided by the ancestors.

50. My ancestors guided me only to become an indigenous healer. They have not taught me to [be a witch and to] harm others. In fact ancestors can not teach you to harm others. They guide us to help others. All those who have evil intentions are not

consulting with members of the community.

48. The graduate healer's skills are further tested in public when he will be expected to find a hidden object. By consulting with those attending the ceremony and also discovering the hidden item, the newly qualified healer earns the confidence of his potential clients.

49. The discovery of a deliberately hidden item is interpreted as proof of the newly qualified indigenous healer's association with the spiritual powers.

50. R makes a clear distinction between an indigenous healer and a witch. Whilst on the one hand a witch is motivated by evil intentions, an indigenous healer on the other hand is motivated by a commitment to help those who are in distress.

guided by ancestors. It is their own evil intentions. A witch is born in a family of witches.

51. A "ngaka" is selected by the ancestors to be of service to the community. Ancestors will thus not tolerate to guide a person who will also have evil intentions to harm others. You are either a "ngaka" or a witch. Our mission as "dingaka" is as good as that of the Western medical doctor who helps people.

52. A person [who ignores a call by ancestors] will never have a peace of mind. The ancestors will haunt him all the way. Even if he may decide to go as far as Johannesburg to dodge the call, the ancestors will follow him there. They will keep haunting him until he is forced to come back home to heed their call. If he continues to ignore this call, the ancestors will make him sick or bring a lot of misfortune to his family.

53. It is possible [to treat a person without first using the divination bones] even though this is not common. Treating a patient without first throwing the bones to discover the nature of his problem is like walking

51. Someone who becomes an indigenous healer has been selected by the spiritual beings to help others.

52. Resisting a call to become an indigenous healer is believed to lead to ancestral displeasure which will be manifested in the form of an illness or bad luck. This unpleasant experience will persist until the person so chosen will heed the call.

53. R relies on his divination bones to establish the nature of the problems and to formulate a treatment plan for his clients.

with your eyes closed. It will be difficult to know whether or not your interventions are appropriate.

54. It may be possible [for a person to learn to divine through the bones without ancestral guidance] to some extent. Such a person will however not be successful because he is not guided by the ancestors. After a while you may find that this person has forgotten everything he has learnt because all the knowledge will not be a gift from the ancestors.

55. On the other hand, someone who is guided by the ancestors will never experience problems like the ones I have mentioned. In fact his diagnostic skills and knowledge of the divination bones will be broadened. The ancestors will usually visit at night to advise him on how he should practice as an indigenous healer. They will even show him where the herbs can be obtained.

56. We have a category of "dingaka" which is called "dingaka tshupsa". These are people who are born in a family of indigenous healers. Often you will find a practising indigenous healer confiding in a

54. Those who simply decide to learn the skills of indigenous healing do not stand a chance of being successful. They may also likely forget what they have learnt after a short while.

55. An indigenous healer will normally be guided by ancestors when he carries out his duties.

56. The scope of a "ngaka tshupsa" is limited to what are seen as straight forward ailments like headaches.

niece, nephew or one of his children. As time goes on, the skills will be passed to this young person who will go on to practice when the indigenous healer dies or is no longer able to carry on with his duties. The scope of a "ngaka tshupsa" is limited as compared to that of a "ngaka" who has been called by the ancestors. For example, a "ngaka tshupsa" will treat the fairly straight forward ailments like head and stomach aches.

57. A "ngaka" on the other hand will handle a wide range of conditions, including those that are brought about by witches and ancestors.

58. You should realize that indigenous healers do not work like the doctors in the hospital. If a patient goes to the hospital, he has to tell the doctor what the problem is. The doctor will then give treatment on the basis of the information that is given by the patient. We do not do that.

59. All we expect the patient to do is to only indicate on arrival that he has come to consult. The patient will be instructed to breathe into the bones and to throw them on the mat. As an indigenous healer I will read

57. A "ngaka" is perceived to be dealing with a wide variety of problems presented by the clients.

58. R makes a distinction between the assessment procedures of an indigenous healer and those of a Western doctor.

59. Whereas a Western doctor relies on the history of the problem as will be provided by the patient, the indigenous healer "reads" the patient's condition from the divination bones.

the patient's problems from the bones.

60. After I will have established the nature of the problem, the patient will be instructed to breathe into the bones again. This second throw of the bones is intended to establish the appropriate treatment programme that will have to be prescribed for the patient.

61. We do not expect the patient to tell us what the problem is. It is our duty to tell the patient what the problem is. The patient is free to disagree with our findings and to even claim his money back in case he is not satisfied with our diagnosis or suggested treatment programme.

62. Usually our patients will be satisfied with our divination sessions and treatment programme. There are many occasions when patients would come back and thank me heartily for the work that I will have done.

63. [To treat mental illness] I will normally follow the same procedures like in the case of other illnesses except that I will have to give the patient medicines that are specifically intended to treat mental illness.

60. R relies on his divination bones to develop a treatment programme for his patients.

61. R plays a more active role during assessment by giving advice and suggestions to the patient.

62. The positive feedback obtained from patients gives R the assurance that his treatment procedures are helpful.

63. R believes that his treatment procedures help people suffering from mental illness.

64. A mentally ill person will usually be brought by the relatives who will complain that he is aggressive, hearing voices, laughing inappropriately or running around.

65. After I will have established the nature of the problem, I will advise the relatives to leave the patient with me so that I can monitor his progress closely. The medicines that I will give to the patient will drive out all these voices and tame the patient. I will usually give the medication in the form of a steam bath.

66. As soon as I am beginning to see improvement on the part of a [mentally ill] patient, I will invite his relatives to come and make their own observations of the patient. This will usually be after three or four weeks.

67. If [the relatives] are satisfied, I will arrange to have the patient discharged. The most important thing to do before the patient gets home is for me to go and strengthen his homestead. If this is not done, the patient will soon come back because the evil forces that are lurking in the homestead will still be there. I have to go and drive out all these evil forces that have caused the illness.

64. Symptoms identified in people who are seen to be mentally ill include, among others, aggression, hearing voices and laughing inappropriately.

65. R prefers to treat those presenting with mental illness as inpatients for the purposes of making closer observations and to monitor progress.

66. The patient's relatives are invited to make an assessment of the progress made by the patient.

67. Apart from treating the individual presenting with a problem, R also carries out some treatment procedures that are seen to free the patient's home from current and potential threats.

68. All family members will also have to be protected so that they do not become mentally ill.

69. Once the patient is sent back home, I will advice the relatives to bring the patient back every year so that I can make follow up treatment.

70. Since the [mental] illness started in the family, it is important for us to make sure that everyone in the family is healthy. The other thing is that if the witches realize that the patient has improved, they may want to come back and strike another member of the family. It is therefore important to protect all the other members against potential illness.

71. Usually the patient will, after a few weeks of treatment, tell me that he is feeling much better. This will in a way also give me an indication that his senses are coming back.

72. The other method of testing wether or not there is improvement is to send the patient to the shops to buy a few items. A patient who has improved will oblige and buy the items as instructed. If the patient is still sick, he will fail to follow the

68. This comprehensive treatment strategy is extended to cover other family members.

69. R does follow up treatment on his patients once they are discharged.

70. Treatment is considered incomplete if the members of the patient's family are not involved at some point.

71. R regards his treatment interventions to be successful when the patient gives a report that he feels much better.

72. R also makes his observations before he gets convinced that the patient's condition has improved.

instructions as directed.

73. One or two cases will at times be difficult to treat. If I realize that the patient does not improve, I will first communicate with my ancestors asking them to show me the best treatment programme.

74. If I fail even after such an attempt, I will consult my colleagues and ask for their opinions. If I fail even with their advice, I will then refer the patient to another indigenous healer who I will consider to be more competent to treat that particular illness.

73. There are some difficult cases that R at times comes across in his practice.

74. R does consult other indigenous healers for their opinions in case he deals with a difficult case. Should this fail, the patient will be referred to another indigenous healer.

Notes

- 1 Treatment - The word "treatment" as used in the context of the central themes has the same meaning in both N. Sotho and English. "Kalafo" (treatment) is a noun that refers to the act through which a person is made to feel healthy or better. "Go alafa" (to treat) is a verb that refers to the act of making a person feel healthy or better. These N. Sotho words and their English equivalents are also included in the glossary.
- 2 The process of assessing - Before an indigenous healer can establish the problem that will need treatment, he/she will engage in a process called "go laola" (to assess). A number of assessment procedures or methods ("mekgwa ya go laola") are used by different indigenous healers. The word "go laola" and its English equivalent are also explained in the glossary.

- 3 Patient - The word "patient" as used in the context of the central themes has the same meaning in both N. Sotho and English. "Molwetsi" (patient) is someone who is ill and in need of treatment. I have included the word "molwetsi" and its English equivalent in the glossary.

CHAPTER 7

PSYCHOLOGICAL DESCRIPTION OF INDIGENOUS HEALING

PART A: SYNTHESIS OF CENTRAL THEMES INTO CONTEXT-BOUND DESCRIPTIONS

7.1. The case of Josephine

7.1.1. Becoming an indigenous healer

From a very early age, Josephine had premonitions as revealed by her dreams which she experienced as strange and worrying. These strange dreams prompted her to embark on some kind of help seeking behaviour. What appears to be a nonchalant attitude shown by her parents drives Josephine to church with the hope that this institution would help her deal with the ego-dystonic experiences that bring discomfort to her. Despite all her efforts, the strange experiences persist until she begins to accept the dreams and to interpret them as indications of a "call" (by spiritual beings) to become an indigenous healer. In other words, what previously had been felt as ego-dystonic is redefined as a meaningful ego-syntonic experience that prepares her to occupy a new and elevated social role in her community.

Whilst Josephine positively redefines her experience as meaningful, her parents (on whom she is still dependent) continue to be dismissive. The tension that develops between Josephine and her parents over these divergent interpretations reaches a breaking point when Josephine gets a sudden attack. It is this particular experience that brings together the extended family (that includes uncles and aunts) to focus on her experiences and finally to agree on a common strategy to consult an indigenous healer who confirms Josephine's interpretation of the illness as a meaningful experience.

By accepting her previously disabling experiences and taking on a new social role, Josephine in essence becomes favourably predisposed to be a facilitator of healing processes when dealing with distressed individuals and their families. By going through a healing experience herself, Josephine is helped to access and confront previously discordant experiences

in her life. This process helps her to develop self confidence and to feel ready to engage others in the process of healing.

7.1.2. Content to be changed

Josephine perceives herself as competent enough to effectively deal with various types of conditions that are presented by consultees. The specific conditions that Josephine identifies are "senyama", mental illness, "sefolane", and "malopo" illness. "Senyama" (or bad luck) is perceived as a highly contaminative condition that predisposes an individual to various illnesses and mishaps. Non-observance of funeral rites and customs, heedless sexual conduct, and mental illness are three factors that are advanced as possible causes of "senyama".

Josephine's understanding of mental illness is that of a disintegrative process which progresses from a prodromal phase (with shyness as one of the early signs) to an active full blown phase that could be characterized by various clinical features that include thought (e.g. hearing voices) and motor (e.g. running around) disturbances. The undesirable experience of mental illness is perceived as a predisposing condition that leads to "senyama".

In the case of "malopo" illness, the clinical picture presented is interpreted either as a reflection of ancestral displeasure or as an invitation extended to someone who is selected to become an indigenous healer. In either case, the "malopo" patient is expected to respond to this communication that is seen to be descending from the spiritual world. Failure to fulfill the wishes of the ancestors is believed to lead to occupational, social, and emotional hardships.

Josephine's understanding of "sefolane" is that of a degenerative and deadly physical condition that will, over a period of time, spread to a victim's entire body. If not treated, this condition is believed to lead to death. "Sefolane", which is commonly identified by swelling of limbs, is understood to be caused by a wide range of factors that include snake bites and crossing certain forbidden paths.

7.1.3. The process to bring change

(a). Establishing nature of the problem: The process of assessment as understood and practised by Josephine is a systematic activity which is perceived to be informed and guided by spiritual forces. Through the use of some assessment tools known as "ditaola", Josephine is in a position to establish the nature of the consultee's problem and to suggest an appropriate treatment / preventive programme. This process includes making a decision on whether or not a consultee will need to be admitted for closer supervision and treatment.

Essentially then, the process of assessment enables Josephine to give a culturally appropriate explanation about the causes of a consultee's distress. This conceptual scheme appears to serve three main functions. Firstly, Josephine's causal explanation of what seems to be a group of nonsensical symptoms reassures the patient who will begin to realize that there is someone who understands his problems. Secondly, the consultee is provided with new information concerning the nature of the distress and how to cope with this unpleasant experience. Thirdly, Josephine's causal explanations serve to strengthen a patient's expectations and to make him feel hopeful about the future.

(b). Treatment goals: Josephine's treatment interventions appear to be mainly aimed at three levels of a consultee's experience. Firstly, the interventions are intended to provide symptomatic relief to the patient's immediate physical and psychological complaints. At the second level, Josephine provides room for the patient's family members to participate in a treatment programme. This form of family participation provides an opportunity for lingering family tensions and conflicts to be enacted and resolved. Thirdly, Josephine's interventions facilitate attainment of transcendental experiences for the patient and family members as they are encouraged to establish a harmonious relationship between themselves and the spiritual world. Considering the above three levels of intervention, it does appear that Josephine adopts an holistic approach in her quest to restore good health to the consultees.

(c). Dealing with the problem: Once the nature of the problem has been established, Josephine will begin to implement programmes that are intended to bring relief to the consultees. The actual healing transactions consist of a series of medical and psychological procedures which include, among others, the use of herbs and performance of culturally appropriate rituals. When progress is observed, Josephine normally invites the patient's family to her place so that they too can make their own assessment of the patient's condition. Apart from playing an important role in assessing the effectiveness of Josephine's treatment programmes (and also offering support to the patient), the family members will most probably benefit as well since the meeting provides a safer environment for family tensions to be resolved.

In the case of mental illness, Josephine applies some strategies that appear to be aimed at testing whether or not the patient is back to his senses. For example, the patient's reluctance to use a leaking container to fetch water will be interpreted as one of the hopeful signs that the illness is remitting. At the same time, the patient will also be observed to show signs of "go swaba" (being shy) which suggest that some degree of social awareness is beginning to show. High level tasks aimed at reality testing include sending the patient to the local shops to buy a few items. If the patient successfully carries out the tasks, he will be sent to town where he will be expected to perform a number of fairly complex business transactions. Apart from establishing a patient's level of contact with reality, these procedures (more especially those involving trips to the shops) appear to facilitate interpersonal contact and to broaden the patient's social network.

Before a patient is discharged, his homestead (understood to include the family members, animals, and even crops) will be treated with some protective medicines that are believed to ward off potential threats. This holistic approach in resolving a patient's problems appears to be intended to emotionally strengthen the patient and his family in such a manner that they will, in the future, be adequately equipped to cope with adjustive demands. It will appear that, in addition to their immediate healing significance, procedures to protect the homestead do play a crucial preventive role insofar as they are understood to ward off potential threats.

(d). Prognostic considerations and difficult cases: Josephine acknowledges the significance of timely intervention as this is seen to improve the chances of recovery. If confronted with a difficult case, Josephine has a number of options available to consider. If the condition is perceived as a "Western" illness, she will refer such a patient to the hospital. For all the other difficult cases, Josephine will first consult a colleague to get advice on how best to help the patient. Should the condition persist, Josephine will refer the patient to a colleague whom she considers to be more competent. Poor treatment progress is usually attributed to unresolved family conflicts or a strained relationship between the patient and the spiritual world.

7.2. The case of Magdalene

7.2.1. Becoming an indigenous healer

The onset of an illness together with what Magdalene describes as strange dreams prompt her relatives to seek help that is intended to restore good physical and mental health to her. After being unsuccessfully treated at a hospital, Magdalene is taken to an indigenous healer who conceptualizes the unpleasant experiences as indications of a "call" to become an indigenous healer. What has hitherto been perceived as distressing and disabling, is now redefined as a meaningful and transcendental experience that will lead to a new and elevated social status in the community. In other words, Magdalene's psychological tensions and conflicts are reinterpreted as a source of strength and adjustive coping. By accepting the "call" and going through the apprenticeship programme, Magdalene is given the opportunity to work through her own conflicts and tensions in a health promoting environment. Such therapeutic gains prepare her psychologically to deal with the various problems presented by the patients.

7.2.2 Content to be changed

In a practice that stretches for a period of over ten years, Magdalene feels competent enough to handle various childhood illnesses and gynaecological problems. She identifies three main types of childhood illnesses, namely "metsho", headaches, and "mootlwa" illness. In the case of "metsho", the child is understood to show a number of anxiety-like symptoms which include restlessness, excessive crying and unwarranted fear of objects in the environment. Childhood headaches on the other hand are described more in terms of physical symptoms which include

vomiting, running stomach and dullness of the eyes. In the case of "mootlwa", the patient is understood to present with excessive coughing, diarrhoea, and chronic stomach problems which, in Magdalene's view do not respond positively to Western treatment methods. These symptoms are understood to be manifestations of an underlying needle-like morbid growth in the child's intestines. Though Magdalene extensively describes "mootlwa" as a childhood illness, she does indicate that this condition can also affect women of childbearing age. If not treated, such a condition is believed to lead to infertility.

7.2.3. The process to bring change

(a). Establishing nature of the problem: Through the assessment method known as "ditaola", Magdalene establishes the nature of a consultee's problem before she embarks on a treatment strategy. By breathing into the "ditaola", the consultee is taken to be projecting his internal badness (pains, tensions, and conflicts) onto these bones. Magdalene will then read and interpret the divination bones in a manner that will be culturally appropriate and understandable to the consultee. The problem that is identified through these projections is communicated to the consultee and family members who will be expected to decide whether or not they would like Magdalene to provide treatment.

There are two important treatment issues that Magdalene appears to address during assessment. Firstly, by revealing the nature of the problem without a background history given, Magdalene makes the consultee feel understood and hopeful that he will be helped. Secondly, Magdalene's procedures are conducted in such a manner that the other family members will be encouraged to be participants during the healing process.

(b). Dealing with the problem: Magdalene's description of "mootlwa" typically illustrates the "how" aspect of her clinical work. Through the divination bones ("ditaola" and the use of a chicken), Magdalene develops a treatment plan that will require the use of both medical and psychological procedures. The chicken, which is made a scapegoat of the consultee's projections, is killed before its diseased organs are extracted and used together with some herbal preparations as an antidote to reverse the condition that is understood to be present inside the patient's body.

Some needles will be used to administer the medicines against this needle-like condition which, in Magdalene's view, can not be removed through Western surgical procedures. This seemingly symbolic use of needles is followed by further treatment procedures that require the patient to take oral medication. Through her own clinical observations and positive feedback given by the patients and their relatives, Magdalene becomes convinced that her treatment interventions are effective.

7.3. The case of Pamosa

7.3.1. Becoming an indigenous healer

What starts as a long illness prompts Pamosa's relatives to embark on help seeking behaviour in order to have good health restored to him. All these efforts become unsuccessful as Pamosa's illness continues unabated. A series of dreams begins to change his life significantly. What previously has been considered an undesirable illness experience is now interpreted as a "call" by the spiritual forces. With this new conceptualization of his physical and psychological experiences, Pamosa begins to feel much better. He now begins to take on a new and respected role in the community. It does seem that the dreams did provide Pamosa with an opportunity to access the unconscious level of his personality and to begin to accept the previously discordant experiences as part of his life. Instead of these experiences becoming more disabling, they provide him with an increased capacity to cope with future adjustive demands.

7.3.2 Content to be changed

In his practice, Pamosa deals with both childhood and adulthood illnesses. He makes mention of two main types of childhood illnesses, namely "bolwetsi bja ditshwene" (monkey disease) and "metsho". A child with "bolwetsi bja ditshwene" will be observed to be too shy and withdrawn. On the other hand, a child with "metsho" will tend to be fidgety and self destructive. Such a child will also be observed to cry intermittently and to show a high body temperature. Both these childhood illnesses are reported to respond favourably and quickly to Pamosa's treatment interventions.

Pamosa identifies several adulthood illnesses which may, on the basis of their clinical features, be classified as either physical or psychological. One physical condition that Pamosa identifies is "vaal siek" (epilepsy). In this case, the patient is understood to have excessive blood that gets congested in the blood vessels and thus lead to seizures. The seizures are therefore regarded as symptoms of an underlying physical condition. Other physical conditions that Pamosa mentions are headaches and gynaecological problems.

Illnesses that could be classified as psychological include "malopo", "ditlajane", and "mafofonyane". Both "malopo" and "ditlajane" afflicted persons will tend to switch into some dream-like states during the active phases of these illnesses. During such seemingly altered states of consciousness, the patient's experiences are believed to be screened out of consciousness. Pamosa does however make a distinction between these two conditions despite their similarities. Whereas "ditlajane" is perceived to be a condition that is brought about by people with evil intentions, "malopo" on the other hand is interpreted as an experience that is associated with the ancestors. In the case of "mafofonyane", the patient will tend to show maladaptive behaviour patterns of a psychotic nature. These include, among others, undressing in public and wandering aimlessly.

7.3.3. The process to bring about change

(a). Establishing nature of the problem: During the "go thwasa" period, Pamosa obtained several items which were put together to comprise his divination set. When a patient comes for consultation, Pamosa will use these divination tools to establish the nature of the problem and also to develop an appropriate treatment plan. This assessment process is believed to be guided by ancestors who are perceived as omnipotent and omnipresent. The divination bones are animated and interpreted in terms of being "awake" or "asleep" at a given moment. For example, Pamosa does believe that only divination bones that are "awake" can lead to a meaningful diagnosis of a patient's condition. What is very important, in Pamosa's view, is to always follow proper assessment procedures so as to avoid making a mistake when it comes to establishing the nature of the problem. Having established what the problem is, Pamosa communicates his clinical impressions in a manner that is culturally appropriate and meaningful to the consultees.

(b). Treatment goals: Pamosa feels that, unlike Western healing methods which are seen to offer symptomatic treatment solutions, indigenous healing does offer permanent solutions which are aimed at the individual, his family, and the total home environment. At the level of the individual, Pamosa's treatment aim is to restore good health to the patient by ridding him of the distressing physical and psychological complaints. At a more broader holistic level, Pamosa seeks to protect the patient, his family and the total home environment from current and potential threats that are believed to be brought about by people with evil intentions. In cases where ancestors are believed to be angered, the aim of the treatment procedures would be to restore a harmonious relationship between the consultee (and his family) and these spiritual forces.

(c). Dealing with the problem: Pamosa has a firm belief that he is always guided by spiritual forces in his clinical practice. This perception is so strong that Pamosa will always attribute his clinical success to the work of the ancestors whom he thanks whenever he is remunerated by his patients. A slump in his practice is subsequently regarded as an indication of ancestral displeasure. It does seem that Pamosa understands his role in the treatment process as a facilitator whose role is to link the healing spiritual forces and the patients.

Whilst providing this crucial link, Pamosa also does apply certain physical and psychological methods of treatment. In the case of physical methods, Pamosa prescribes medication which may be administered orally, intravenously or nasally. Some of the medicines administered (like those mixed with pig fat) are believed to have the potency to counteract conditions that may have been brought about by people with evil intentions. Pamosa is however aware of the dangers of overdose hence he always advises his patients to follow strict instructions when they take their medication. In his description of the procedures that are followed to treat "vaal siek", Pamosa does emphasize the importance of medicines and the need to abstain from meat and salty food as these items are seen to counteract the pharmacological activity of the medicines.

Though Pamosa may not use psychological terminology, it does seem that most of his treatment procedures are essentially psychological in focus. For example, Pamosa establishes good rapport and show genuine interest in his patients by relating to them as if they are members of his family. He does also provide ample time for the patients to relax whilst they are in his care. Towards the end of a treatment programme, Pamosa engages other family members and proceeds to their home where he will carry out further treatment procedures. In order to assess the effectiveness of his interventions, Pamosa will rely on his clinical observations and the positive feedback that he gets from the patient's relatives.

7.4. The case of Rammalo

7.4.1. Becoming an indigenous healer

What is perceived as an illness prompts Rammalo's relatives to first consult Western trained health professionals before they solicit the services of an indigenous healer. Instead of defining the condition as a disabling experience, the indigenous healer interprets the symptoms as an indication that Rammalo has been chosen by the spiritual beings to become an indigenous healer. This re-conceptualization of the experience leads to a period of apprenticeship during which Rammalo acquires the skills required to practice as an indigenous healer. Whilst going through the apprenticeship period, Rammalo gets an opportunity to focus on his unpleasant feelings and to work through unresolved conflicts and tensions - a necessary preparatory and psychological experience for a healer. On completion of his training, Rammalo enters into a partnership (with his brother) which gives him the opportunity to gain experience and confidence before setting up his own practice.

7.4.2. Content to be changed

Rammalo identifies a wide range of conditions that he believes he is in a position to treat. One such condition is mental illness which is the most common complaint presented by the majority of his patients. Symptoms identified in people who are suffering from mental illness include, among others, hearing voices and laughing inappropriately. Another condition that Rammalo describes extensively is "senyama" (bad luck) which is understood to predispose an individual to other illnesses. What is suggested here is that by contracting "senyama" (understood to be

highly contagious), the individual's physical and psychological immune systems are weakened (or destroyed), thus making him vulnerable to attack by other illnesses. Three major causal explanations are given for this condition. First, it is believed that heedless sexual relations between a man and a woman who has aborted a pregnancy may lead to "senyama". Second, "senyama" may be brought about by non-observance of funeral customs and rites. For example, at the end of a funeral service, one is expected to wash his hands before having a meal. Failure to observe this hygienic practice is understood to lead to "senyama" which may then be "carried" by those infected and thus stand the risk of harming their own families. Third, it is believed that some people in the community are simply driven by evil intentions and jealousy to harm others. People so harmed will develop "senyama". Other conditions that Rammalo believes he is competent to treat include "malopo" illness and sexual problems.

7.4.3. The process to bring change

(a). Establishing nature of the problem: As soon as a consultee arrives, Rammalo communicates his appreciation to the spiritual forces whom he believes will have made the referral. After a normal social chat to establish rapport, Rammalo will invite his patient into his consulting rooms which are understood to be protected by the ancestors. Unlike a Western oriented doctor or psychologist who relies on the history supplied by the patient, Rammalo will "read" the patient's condition from the divination bones. These assessment tools will further give an indication of the appropriate treatment programme that should be followed. Rammalo will then communicate his clinical impressions to the patient and the accompanying relatives who make a decision on whether or not they would like him to help them.

(b). Treatment goals: As soon as a patient arrives, Rammalo will embark on a treatment programme that is aimed at the individual, the family, and the total home environment. In other words, while the individual's good health is restored, Rammalo will also seek to deal with the tensions and conflicts within the family as well as those current and potential threats that are perceived to come from outside this closely knit social system. It appears therefore that Rammalo's treatment interventions are holistic insofar as they are aimed at the individual, his family and the total home environment.

(c). Dealing with the problem: Rammalo sees himself as an authentic indigenous healer with the competence to handle a variety of conditions presented by the consultees. Before embarking on a treatment programme, Rammalo will communicate with the spiritual beings who he believes are instrumental in bringing about positive change on the part of the patient. Once this has been done, Rammalo will take the patient through an assessment and treatment process. The initial fee that is to be paid will indicate the degree to which the patient and his family are committed to treatment.

Through a series of medical and psychological procedures, Rammalo will engage the patient in a healing process that is believed to be constantly guided by the spiritual forces. In the case of medical procedures, Rammalo will normally use an assorted range of herbs to bring about the desired effect. These herbs are usually derived from tall trees as these are believed to "blow away" the illness from the patient's body. In addition, Rammalo will usually add special water obtained from the sea or waterfalls as this is seen to have a purifying effect on the patient's home environment. Whatever the pharmacological activity, Rammalo's treatment procedures appear to have a strong symbolic significance which promote healing.

It does appear that most of Rammalo's treatment procedures are psychological in nature even though he may not define them as such. For example, Rammalo will seek to involve other members of the consultee's family throughout the process of treatment. As soon as he is satisfied with the progress made by the patient, Rammalo will invite the consultee's family to come and make their own assessment of treatment progress. Before the patient is discharged, Rammalo will also arrange to have the family members and home environment protected from current and potential threats. By being involved in this seemingly holistic process, the family members get an opportunity to enact, in a safer environment, some of the lingering tensions and conflicts. Another area where a lot of psychological procedures are manipulated to effect positive change is in the case of "malopo" illness. Once a patient is found to be suffering from "malopo", he will be expected to go through the "malopo" dance. Through rhythmic drumming, hand clapping and song, the spiritual beings are believed to be invoked and to manifest themselves through the possessed individual. Rammalo will interpret what appears to be the patient's altered state of

consciousness as a reflection of ancestral presence.

Throughout the process of treatment, Rammalo uses three methods to assess progress made by a patient. First, he will constantly observe his patients before he can be convinced that there is meaningful treatment progress. Second, he will rely on the subjective reports that the patient gives about his condition. Third, Rammalo invites the patient's relatives to make their own assessment on whether or not the patient has improved. It is on the basis of these evaluations that Rammalo will be convinced about the effectiveness of his treatment procedures. Whilst he regards himself to be generally successful in his clinical practice, Rammalo does concede that there are cases that he sometimes fail to treat. Such cases will be referred to other indigenous healers who are taken to have specialized skills.

<i>PART B FROM CONTEXT-BOUND DESCRIPTIONS TO PSYCHOLOGICAL DESCRIPTIONS OF INDIGENOUS HEALING</i>

7.5. "Go thwasa" is a preparatory step that leads to integration of personality, acquisition of clinical skills, and attainment of transcendental experiences.

Becoming an indigenous healer is a long and arduous process that begins with what is perceived as an illness and unpleasant dream experiences. The physical and psychological symptoms experienced will usually be of such a severe nature that the individual's previous level of functioning will be considerably affected:

[Pamosa] "Before I started practising as an indigenous healer, I became seriously ill and spent twelve months in bed. During this time I could not eat or talk to anybody. My illness was so serious that even my relatives thought I was going to die"

[Josephine] "As far as I can recollect events of my childhood, I have always been having strange dreams ... I used to see people that I know very well dying ... These dreams worried me so much that I got very scared ... I remember even going to church with the hope that being in church would help drive away these strange and unpleasant dreams"

The illness and unpleasant dream experiences, like the ones reported above, will prompt the distressed individual together with his family to seek help. At this point, help seeking will still be aimed at dealing with what is perceived as a disabling experience that interferes with an individual's social and occupational functioning. From the very beginning, other family members become involved in this process that will be aimed at helping the distressed individual. The illness and unpleasant dreams will be of such a serious nature that they will threaten to disorganize the entire family system. Seeking help could be seen as a way for the family system to restore equilibrium.

It is the indigenous healer consulted who will redefine the illness or unpleasant dreams as meaningful experiences which are associated with spirituality and a vocation. Instead of referring to the physical and psychological complaints as indications of a disability, the indigenous healer will regard them as proof that the experiencing individual concerned has been chosen to become an indigenous healer:

[Josephine] "On arrival he [indigenous healer] threw his divination bones and advised that my strange behaviour was an indication of a call to become an indigenous healer. He referred me to another indigenous healer who has a good reputation of training people to become indigenous healers"

This new conceptual framework given by the indigenous healer transforms illness into an ego syntonic experience that becomes a source of strength and knowledge. By going through "go thwasa", the individual is engaged in a process of role reversal that transforms him into a valued and knowledgeable person capable of alleviating the afflictions of others. "Go thwasa" appears to serve three important functions, namely, integration of personality, acquisition of clinical competencies and the attainment of transcendental experiences.

In terms of personality integration, "go thwasa" could be seen to provide an opportunity for the budding indigenous healer to confront and work through the unacceptable feelings and incongruent behaviour patterns that are a source of distress. By the end of the process, the individual will have been sufficiently exposed to a therapeutic experience that promotes self

acceptance and the attainment of emotional preparedness to deal with other people's problems. The process of becoming an indigenous healer could thus be seen to be providing an opportunity to integrate previously discordant aspects of the self into a more solid and congruent personality structure. The finding that becoming an indigenous healer is not disintegrative but a meaningful experience is in keeping with findings made by other phenomenologically oriented investigations that have sought to understand and describe "go thwasa" among the Nguni people (Kruger, 1974; Schweitzer & Buhrmann, 1978). Looking at the same experience from a Jungian perspective, Buhrmann (1990) is of the view that "thwasa" is a transition towards individuation. As she put it:

"The very word 'thwasa' means transition, the birth or emergence of something new. With the gradual integration during treatment of new aspects and the development of new potential, the person becomes more whole and thus, in a sense, more individual. His newly acquired abilities are, however, usually not to be used for personal aggrandizement, but in the service of his community and at the behest of the ancestors" (p.206).

In terms of the second function (i.e. acquisition of clinical competencies), "go thwasa" provides an opportunity for an individual to go through a long period of apprenticeship as illustrated by the following extracts:

[Rammalo] "I was trained by my brother who was an indigenous healer. He taught me all the skills like divination and how to use the various herbs. He took me through all the stages of 'go thwasa' before I ultimately graduated as an indigenous healer".

[Magdalene]: " ... I was trained for almost a year before I was discharged".

[Josephine]: "I went through the training programme and on my return home at the end of 1972, I was a fully fledged indigenous healer. The training lasted for four years".

In terms of the third function, "go thwasa" could be seen to provide an opportunity to attain transcendental levels of experience. The dreams appear to sensitize the "go thwasa" person to relate to the spiritual world in a way that was previously not possible:

[Pamosa] "One day I had a dream that ultimately changed my life. In my sleep I saw my grandmother approaching... From that day onwards I started having a lot of dreams through which my grandfather would show me different types of divination bones and medicines that I was supposed to use as an indigenous healer."

[Josephine] "My ancestors guide and indicate to me the kind of person who will be coming to see me ... Everyday before I go to sleep I will sprinkle a little snuff on the floor and talk to my ancestors".

In the above extracts, the indigenous healers perceive ancestors as forces that can vividly be "seen" and "talked" to. These "visions" and "communications" which have now become acceptable, make the individuals concerned to feel unique and capable of accessing those realms of experience which are beyond the reach of ordinary individuals. Several other investigators have made similar observations in the case of indigenous healers (Buhrmann, 1979; 1982a; 1982b; Kruger, 1974; Schweitzer, 1977a) and shamans (Kakar, 1982; Peters, 1989; Walsh, 1989). Whilst both the indigenous healers and shamans can "see" and "talk" to the supernatural beings these two groups seem to differ in the way they access this transcendental reality. For example, whereas the shaman's soul is believed to leave his body and journey to the sky or descend to the underworld (Thorpe, 1993), the indigenous healer on the other hand is perceived to be "visited" by the ancestors who take possession of his body in the ordinary world.

At the end of the apprenticeship period, the newly qualified individual will be physically and mentally fit to be taken home:

[Rammalo] "Once all the steps have been followed, arrangements will be made to take the trainee back home. The trainee's relatives will organize a big party that will take place on a Friday up to a Sunday when we will leave the trainee at his place. This will mean that he is ready to start practising as an indigenous healer".

The "take home" ceremony as described by Rammalo appears to communicate three important messages. First, by allowing the trainee's relatives to arrange for the festivities, the indigenous healer is in effect saying that the trainee is emotionally fit and clinically prepared to

function independently as a member of society and also as a helper of those in distress. Second, the involvement of relatives during these home-comings will make the client to feel accepted, respected and accommodated within the family system after a period of absence. Third, the participation of other community members makes the "go thwasa" person to have a sense of connectedness to the broader social world.

7.6. Indigenous healers attach culturally congruent labels to clusters of physical and psychological symptoms presented by their clients

One of the most crucial tasks of the indigenous healer is to use a culturally appropriate explanatory model to interpret what, to the patient, is experienced as a cluster of nonsensical and distressing symptoms. This interpretation or naming process presupposes that the language used by the indigenous healer is accessible, comprehensible and culturally consistent with the patient's world view. For example, in his explanation of headaches, Pamosa points out that a pathological condition can be transferred from a human body to another living entity:

"The residue derived from these burnt herbs is ground into a 'tshidi' which is applied to a thin rope that is going to be tied around the patient's head. After a few days, the patient will be instructed to go to the bush and untie the rope from his head. This is then tied onto a tree ... The patient will get better because his illness has been transferred to a tree in the bush".

Magdalene also talks about disease being transferred from a human body to another living entity:

"To locate its ['mootlwa'] exact position inside the body, we will make use of a live chicken which the patient will be advised to bring ... The patient will be requested to 'huetsa' (breathe into) the chicken before it is slaughtered. By breathing into the chicken the disease is transferred from the patient to the chicken".

The pathology transfer principle as suggested in the above two extracts is extended to explain other morbid conditions like "senyama":

[Josephine] " ... 'senyama' has got many meanings because it is caused by a wide range of things. It may roughly be understood as darkness or bad luck. For example, if you attend a funeral you get 'senyama' and this has to be washed immediately when you return from the cemetery. This kind of 'senyama' can only be rubbed off by washing your hands before you leave the deceased's home. Failure to do so will lead to contamination that may be detrimental to the health of your family".

The above extracts give an illustration of how the indigenous healer explains illness in a language that is understandable and accessible to the patient. It is clear that the above causal explanations would not be easily comprehensible to a patient with a Western cultural orientation. It seems therefore that the naming process is culturally patterned and inextricably linked to a patient's world view. Several other studies have also pointed out that the success of any therapeutic encounter hinges largely on the ability of the patient and healer to synchronize their conversational and nonverbal exchanges within the context of a particular cultural environment (Connor, 1982; Kleinman, 1988; Lebra, 1982; Sue & Zane, 1995) According to White and Marsella (1982), such therapeutic encounters require "a certain degree of sharing of linguistic and cultural knowledge by which interpretations are negotiated through questioning, answering and nonverbal interaction" (p.29).

The point about cultural congruence as suggested above is further illustrated by what could be regarded as the supernatural theory of illness causation. For example, the indigenous healer may suggest to the patient that his condition is caused by some omnipotent ancestral forces that have control over people's health. Such forces are seen to take possession of the individual and thus lead to a condition known as "malopo":

[Rammalo] "In the case of 'malopo', one is troubled by people who have passed away, that is, grandparents and great grandparents. By beating the drums during the 'malopo' sessions, we are inviting the ancestors to come closer ... With repeated drumming, hand clapping and song, the possessed will start shaking and crying. At this stage we will know that the ancestors have come closer".

A person possessed by "malopo" will have to go through a series of rituals in order to have the condition ameliorated. Apart from the therapeutic significance of the "malopo" dance, the individual so possessed will also be seen to be special in the sense that he can relate to the spiritual world in a way that is not possible for other people.

Another supernatural theory of causation relates to what is described as witchcraft. Some people are believed to harbour evil intentions to an extent that they may manipulate some malevolent forces to harm others:

[Rammalo] "Some people may invoke 'senyama' to strike a young man who is planning to go to Johannesburg to look for a job. Even after repeated attempts to secure a job, such a young man will not succeed. The witches are responsible for his misfortunes".

Apart from giving an appropriate causal explanation for the above conditions, the indigenous healer will also suggest an intervention programme that will be aimed at restoring good health to the distressed individual.

Whilst the indigenous healer does not explain the various illness categories in terms of the body-mind dichotomy which characterizes Western psychology and medicine, we can however discern that there are conditions that predominantly have a physical manifestation and those that are manifested psychologically. Physically manifested illnesses include conditions like "sefolane" and "vaal siek":

[Josephine] "A person with 'sefolane' will show a swelling in the limb that has been affected. The swelling will keep on spreading to affect the other limbs and ultimately the whole body until the patient dies if not properly attended to".

[Pamosa] "The cause of 'vaal siek' is excessive blood in the patient's system thus leading to congested vessels. Once this happens, the patient collapses ... The excessive blood will be clearly visible inside the goat. This congested blood chokes the veins and thus lead to the intermittent seizures. It is a very dangerous disease because if the patient is alone at the time of the seizures, he may die".

Though the causes of "sefolane" and "vaal siek" may not be the same, the individual suffering from any of these two conditions will present with a number of symptoms that will suggest that there is something physiological that is malfunctioning. Even the treatment proposed by the indigenous healer will primarily be aimed at normalizing the physiological functioning of the diseased organ in the body.

The following extracts on the other hand give the impression that there are some psychologically manifested illnesses in addition to the physical conditions that the indigenous healer deals with:

[Rammalo] "A mentally ill person will usually be brought by the relatives who will complain that he is aggressive, hearing voices, laughing inappropriately, or running around".

[Josephine] "A person who is mentally disturbed is also having 'senyama'. It is as if he is dead because he does not realize that he is out of touch with reality and behaving inappropriately. He may use a container that is leaking to fetch water without realizing that his action is inappropriate. His sense of judgement is gone".

In concluding this section, it could be stated that there exists a definite conceptual system that guides the indigenous healer in his attempt to make sense of a patient's symptoms. Based on the symptoms presented, the indigenous healer will formulate a diagnosis which is communicated in a language that is accessible, culturally congruent and thus understandable to the patient.

7.7. Indigenous healing is a multi-phasic process that is aimed at the client and the total home environment while at the same time providing an opportunity for others to access spiritual dimensions of their experiences.

7.7.1. The three phases of indigenous healing

An analysis of the protocols suggests that the process of indigenous healing can essentially be divided into three phases. Each of these three phases will be presented separately even though there is a great degree of overlap that exists.

(a). The initial phase: Through what is perceived as dealings with the spiritual world, the indigenous healer will "know" beforehand about the imminent arrival of a patient. In some cases, the exact day and time of arrival may even be known. Josephine explains this pre-consultation briefing by the ancestors as follows:

"My ancestors guide and indicate to me the kind of patient who will be coming to see me. My ancestors will even show me the nature of his problems. When he arrives here I will be ready".

What is suggested here is that the actual patient-healer encounter is a continuation of a process that will have begun with a dialogue between the indigenous healer and his / her guiding ancestors. In other words, before any consultation can take place there will be a reasonable level of anticipation and psychological preparedness on the part of the indigenous healer to deal with the patient's problems. As soon as the patient arrives, the indigenous healer will initiate a social chat that appears to facilitate attainment of the first therapeutic task, namely, establishment of rapport. After breaking the ice, the indigenous healer will invite the patient (usually accompanied by relatives) into the consulting room. With a reasonable working relationship negotiated and developed, the indigenous healer will seek to identify the nature of the problem that has brought the patient for consultation. This could be regarded as the second therapeutic task of the initial phase. Using appropriate diagnostic tools like "ditaola" (divination bones), the indigenous healer will be in a position to arrive at a diagnostic formulation on the basis of which treatment will be suggested. The following extracts illustrate the central role that is played by "ditaola" in problem identification:

[Magdalene] "The first step that we take when a patient comes to consult is to throw the divination bones. These bones will give an indication to us as to what the patient's problems are ... We do not expect the patient to reveal the nature of his problems to us. We can read all that from the fall of the bones".

[Josephine] "The divination bones are my extra eyes. They will indicate many things to me. From the fall of the bones I can tell everything about the patient".

It is clear from the above extracts that the indigenous healer will not regard the fall of the bones as accidental. Instead the ancestors are believed to influence the way the bones are going to be positioned. In addition, these spiritual forces will even "write" the messages on these instruments which can only be "read" by a properly qualified and spiritually guided indigenous healer. These messages, together with the indigenous healer's clinical observations constitute samples of information that will be put together to formulate a diagnosis. The diagnostic picture so formulated is then communicated in a culturally appropriate manner to the patient who is free to agree or disagree with the indigenous healer's interpretation. If there is an agreement, the patient will be expected to commit himself to a therapeutic process by advancing an initial fee payment. In other words, once the problem has been identified and communicated, payment of an initial fee will be considered to be a commitment by the patient to enter into a therapeutic relationship.

(b). Treatment phase: This phase can be taken to begin immediately after an initial fee payment. The most important therapeutic task during this phase is the administration of physical and psychological therapies. In the case of physical therapies, the indigenous healer will prescribe medicines which are derived from various sources including herbs, oily substances, soil, and sea water. In his explanation of the medicines that are used to treat "vaal siek" Pamosa says:

"... we will remove the diseased organ from the goat and mix this with some herbs which will be given to the patient to 'orela'. The 'tshidi' derived from these burnt medicines is applied to the patient's body though 'go hlabela'. The remaining 'tshidi' is given to the patient to take home. This will have to be taken regularly with soft porridge".

Whatever their pharmacological properties and physiological effects, these medical preparations appear to have a strong symbolic value during the process of indigenous healing. It is at this symbolic level that the indigenous healer and the patient are able to communicate meaningfully. In her explanation of "mootlwa", Magdalene expresses this sentiment. For example, she does point out that needles are used to administer the medicines to treat what she perceives as a needle-like growth that will be lodged in a patient's body.

The second treatment approach, which appears to have a great symbolic significance, entails the performance of rituals which include protection of homesteads and the restoration of harmonious interpersonal and person-ancestor relationships. Rammalo gives the following explanation of how a homestead is protected against the deeds of evil forces:

"We use a variety of herbs. Of course we have to add 'tshidi ya badimo' to all these preparations. The other ingredients will include barks, leaves, and roots of tall trees, bits of soil from the mountains, sand, and water from the sea. All these ingredients are mixed and sprayed all over the homestead".

Restoration of harmonious relationships between people and ancestors involves performance of rituals that require animal sacrifices. For a woman who presented with what could be described as panic attacks and insomnia, Pamosa diagnosed these symptoms as indications of ancestral displeasure and suggested that an ox be slaughtered in addition to medicines that were given to her.

Though performed for different reasons, the rituals described above by Pamosa and Rammalo appear to have two common psychological elements. First, the animal that is killed could be seen as a scapegoat onto which personal and group conflicts are projected. By killing the scapegoat, the undesirable tensions and conflicts are thus symbolically removed from the patient's body. Second, the entire process involves giving suggestions which come as instructions to be strictly followed. This continuous barrage of suggestions will gradually condition the patient to accept the diagnosis. By accepting the diagnosis, the patient will thus be poised to be responsive to the indigenous healer's subsequent therapeutic moves.

The second therapeutic task that the indigenous healer will seek to accomplish during the treatment phase (particularly in the case of inpatients) is to gradually reintroduce the patient to the family whilst at the same time termination of the therapeutic relationship is implicitly negotiated. The family members will usually be invited to the indigenous healer's place where they will be expected to interact with the patient in the presence of the indigenous healer. Josephine gives the following explanation of how she would handle somebody recovering from

mental illness during this phase:

"... I will invite his relatives to my place to come and have their own assessment of the patient. In their presence I will request the patient to perform certain tasks ... All these tasks that the patient is requested to perform are meant to test his ability to relate to the relatives and to judge if his condition has improved".

Apart from assessing treatment progress as suggested in the above extract, the family members present could be seen to facilitate a family therapeutic process. By participating at this stage of the healing process, the family members are facilitating re-entry of the patient into the family system. In the process of interaction, some lingering family tensions and conflicts will be enacted and resolved in a fairly safer environment that the indigenous healer will have provided. Soon after these meetings, the indigenous healer will make a home visit before the patient is discharged. The purpose of such a visit will be to protect the entire homestead from potential illness. As Rammalo explains:

"All family members will also have to be protected from becoming mentally disturbed".

It would appear that the central aim at this stage of the treatment phase is to reconstitute the family system so as to accommodate the returning member and to also equip family members with the necessary skills to deal with potential conflicts and tensions should these arise in the future.

(c). Terminal phase: On the basis of his / her own clinical observations that will be supplemented by the subjective reports from the patient and relatives, the indigenous healer will establish whether or not therapy has been successful. If satisfied, the indigenous healer will terminate therapy, and in the case of inpatients this will be accomplished by taking the patient back home. In so doing, the indigenous healer is demonstrating a genuine interest in the well being of the patient beyond the immediate clinical environment. This demonstration of genuine interest is further reflected in the indigenous healer's provision for follow up consultations with patients after they will have been discharged. The following extracts illustrate this point:

[Josephine] "I will usually give the patient's relatives a period of three to four months to observe him at home in terms of how he relates to them. What I have often seen is that the relatives will normally approach me even before the three to four months to thank me for the services rendered".

[Rammalo] "Once the patient is sent back home, I will advice the relatives to bring him back every year so that I can make a follow up".

A few comments can be made on the basis of the above extracts. First, termination of the process of indigenous healing is a gradual process that takes place over a long period of time. Second, the follow up consultations provide the indigenous healer with an opportunity to assess the patient's adjustive skills in dealing with the external world. Should these adjustive skills be seen to be inadequate, the indigenous healer will offer extra therapeutic services to strengthen the patient and family. Third, the family becomes a very crucial component of the rehabilitative programme. The indigenous healer encourages the other family members to be actively involved in observing and supporting the patient during this crucial phase of the therapeutic process.

From the above discussion, it does appear that indigenous healing is an organized healing tradition that follows certain stages. In the case of Western healing systems, the process of psychotherapy is also divided into several stages. For example, Wolberg (1967) in his book "*The techniques of psychotherapy*", also identifies three phases in the process of psychotherapy. During the beginning phase of treatment, the therapist's objective is to establish a working relationship with the patient. The main objective of the therapist during the second or middle phase is to uncover the causes and dynamics of the patient's disorder. During the third phase, the task of the therapist is to facilitate optimal functioning and independence on the part of the patient. Brammer and Shostrom (1977) who saw the main goal of (Western) psychotherapy being to help a patient to discard rigid and dysfunctional life styles in favour of more flexible and creative behaviour patterns, identified seven essential steps that they believed a therapist will need to follow during the process of therapy. Overall, the seven stages identified by Brammer and Shostrom, and the three phases of psychotherapy as elucidated by Wolberg, appear to have certain goals in common. For example, in these two therapeutic traditions (i.e. indigenous and

Western healing) the main goal of a healer during the beginning / initial phase is to establish rapport with the patient.

7.7.2. Levels of intervention

While the indigenous healer will commonly follow the three phases outlined above, there are essentially three levels at which his / her interventions will be focused. For some conditions, intervention may be directed at all the three levels. Though there exists no watertight boundaries between the three levels that will now be discussed, I will however present each one of them separately.

(a). Individual level of intervention: Certain conditions that the patients present with will need the indigenous healer to focus predominantly on the individual patient in order to restore a feeling of physical and / or psychological well being. For example, in the case of "mootlwa", the physical symptoms presented will be interpreted as manifestations of a disease that is lodged inside a patient's body. The treatment programme that the indigenous healer will recommend will primarily be aimed at removing the morbid condition in order to bring a feeling of well being to the individual patient. In his explanation of how he would treat "vaal siek", Pamosa gives the impression that this physically manifested illness does need intervention strategies that will primarily be aimed at the individual level. Apart from some physical therapies like "go hlabela" and "go orela", the patient will be instructed to avoid certain types of food as these are believed to counteract the pharmacological activity of the medicines.

Though this study could not establish the pharmacological effects of the medicines used, it does appear that these preparations have some psychological values. For example, breathing into an animal during a diagnostic session could be interpreted as a way of projecting one's internal badness, conflicts and tensions onto an external object. By killing the scapegoat, the illness is symbolically removed from the patient's body. The instruction given to the patient to avoid certain types of food seems to be a kind of suggestion. The indigenous healer is in a way saying to the patient: "I know what will bring relief to you. If you avoid red meat and salty food, you will feel much better". Several studies have also emphasized the role of suggestion in the

healing traditions of Africa (Awanbor, 1982; Kiev, 1989; Peltzer, 1990; Prince, 1974; Zempleni, 1977).

(b). Family level: At this level of intervention, the indigenous healer aims at the total home environment which is made up of the people, animals, crops, houses, and in fact all the entities within the parameters of the homestead. The following extract taken from the interview with Josephine illustrates this point:

"[The aim of treatment is to] help everybody in the homestead, including the wife, children and even livestock and crops. When we say that the person is okay we are also saying that his home, his children, and his belongings are okay. If we do not address the entire home environment, he will get sick again and come back to us".

The above extract raises a few important points. First, by targeting the broader home environment, the indigenous healer is essentially defining the problem in systemic terms. The family is perceived holistically hence the approach to restore good health will be aimed at the entire family system. In other words, healing takes the form of restoration and reconstitution of a family system that is perceived as malfunctioning. The malfunction of one unit within the broader family system will negatively affect the other units that collectively make up the whole. Second, by engaging the family unit, the indigenous healer is in a way addressing those existential tensions and conflicts that are characteristic of any family system. Third, targeting the broader home environment could be seen as a preventive strategy that is aimed at protecting the family system against external potential threats.

(c). Spiritual level: For certain categories of experience, the indigenous healing could be seen to facilitate attainment of feelings of transcendence and connectedness with the spiritual forces. Three such categories are "go thwasa", "malopo" and performance of rituals. As already discussed in an earlier section, "go thwasa" person will be regarded as someone who is chosen by the ancestors to help those in distress. From time to time, such a person will experience dreams which are interpreted as messages from the spiritual world. In other words, the "go thwasa" person is believed to be imbued with special abilities to enter and exit the spiritual world

as and when it becomes necessary. Psychologically, these dream experiences could be seen as an avenue for the individual to work through inner tensions and conflicts.

In the case of "malopo", the individual possessed will apparently switch into altered states of consciousness following rhythmic drumming, hand clapping and singing. During such states, the individual is believed to become a medium through which the spiritual beings make their needs known. The utterances that such a person will make whilst possessed will be regarded as important ancestral messages. Usually, these altered states of consciousness will persist until the possessed person performs the "malopo" dance. It does appear that the entire "malopo" experience does, apart from its spiritual significance, provide an opportunity for emotional and physical catharsis. The cathartic effect of the "malopo" experience and other similar transcendental experiences have also been suggested by previous studies (Buhrmann, 1989; Olivier, 1985; Van Der Hooft, 1981; Walsh, 1989).

For the cases where performance of rituals is prescribed, the patient will be joined by other family members in sacrificing an animal. During such moments, some prayers and incantations will be recited so as to summon the spiritual beings to come closer. After all the necessary ritual procedures, relations between the living and the ancestors will be taken to have been re-established or strengthened. Failure to observe such rituals is believed to lead to illness or misfortunes.

7.8. Concluding remarks

The aim of this chapter was to synthesize the natural meaning units and central themes provided in Chapter 6 into psychological descriptions of the process of indigenous healing. Three such consistent psychological themes were extracted and these have been presented in Part B of the present chapter. Given the findings of this study, it could be argued that indigenous healing is a logical and culturally patterned therapeutic system that needs to be developed, legitimized, and utilized as a health care resource in South Africa. The issues relating to possible utilization of indigenous healing are discussed in the following chapter.

CHAPTER 8

IMPLICATIONS FOR MENTAL HEALTH POLICY IN SOUTH AFRICA

8.1. Introduction

The aim of this chapter is to open a dialogue about links between indigenous healing and the modern health care system. The first section of the chapter will focus on international developments regarding the training and utilization of indigenous healers in different parts of the world. Proposals and guidelines made by the World Health Organization on how governments in developing countries could utilize the services of indigenous healers will be reviewed. Three countries namely, China, Ghana, and Zimbabwe will then be selected for the purpose of illustrating how specific governments have tried to accommodate indigenous healing as a national health care resource. The second section of the chapter will focus on the place and role of indigenous healing in South Africa. Various research studies about the attitudes of different stakeholders (like health professionals, consumers, and indigenous healers themselves), will be reviewed. In addition, the current position of the South African government as well as the views of organized traditional healers associations and other voices will be discussed. The last section will focus on the problems and prospects of linking indigenous healing and modern health care system in South Africa. The national options that could be considered will be presented while specific suggestions are going to be made by the researcher regarding what the appropriate role and place of indigenous healers in South Africa could be.

8.2. International trends

8.2.1. The role of World Health Organization

In 1975, a World Health Organization (WHO) Executive Board made the following proposal with regard to the training and utilization of traditional healers and their collaboration with health care delivery systems:

"Traditional healers deal with a wide spectrum of problems and they constitute a large reserve of health manpower but their activities seldom receive official mention. Proposals are therefore made for the collection of information, the development of appropriate training programmes and studies and research, in order to improve the services of healers and to facilitate their collaboration with the primary health care systems" (World Health

Organization, 1975, p.1).

This proposal was endorsed by the 29th WHO Assembly (held in May of 1976) which requested that traditional healers be considered as a valuable health manpower reserve. This position resulted in the organization of the Working Group on Traditional Medicine which was established at WHO in Geneva in June 1976. The specific objectives of this Working Group were to:

- # foster a realistic approach to indigenous medicine in order to improve health care;
- # evaluate traditional medicine in the light of modern medicine so as to maximize useful and effective practices and discourage harmful ones; and,
- # promote the integration of proven valuable knowledge and skills in traditional and Western medicine (Bannerman, 1977).

At the historic International Conference on Primary Health Care held in Alma-Ata (Russia) in 1978, the delegates issued a report which in part read as follows:

"Traditional medical practitioners and birth attendants are found in most societies. They are often part of a local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices ... It is therefore well worth while exploring the possibilities of engaging them in primary health care and of training them accordingly" (World Health Organization, 1978a, p.63).

In subsequent meetings of the World Health Organization and some of its structures, the role and place of indigenous healers has regularly featured on the agenda. For example, in one of the meetings of the WHO Health Assembly, the following resolution on the desirability of cooperation between traditional medicine and modern (Western) health care systems was passed:

"Member States were urged by the Health Assembly to encourage collaboration among universities, health services, training institutions and relevant international organizations in the scientific appraisal of traditional forms of medical treatment and their application, when indicated, in modern health care" (World Health Forum, 1989, p.281).

In keeping with this resolution, there are now at least 24 WHO Collaborating Centres for Traditional Medicine in various parts of the world (National Select Committee on Social

Services, 1997). The main role of these centres is to support WHO in implementing its policies and decisions regarding indigenous healers.

These vigorous efforts by the World Health Organization gave impetus to efforts by several governments in developing countries to consider utilizing the services of indigenous healers (Jeffery, 1982; Jingfeng, 1988; Kapur, 1979; Neuman & Lauro, 1982; Sharma & Ross, 1990). A number of countries in Africa have also followed this path (Green & Makhubu, 1984; Maclean, 1986; Pillsbury, 1982; Warren, 1986), with Zimbabwe as the most recent example (Chavunduka, 1986, 1995; Dauskardt, 1990; Freeman, 1988; Korber, 1990). I will now look at how a selected number of countries, in line with the WHO efforts, have attempted to utilize the services of indigenous healers in their national health care systems. In this regard the discussion will specifically focus on The People's Republic of China, India, Ghana, and Zimbabwe.

8.2.2. The People's Republic of China

Despite the persistence of traditional Chinese medicine through the ages and its deep roots in Chinese culture, religion, and philosophy, Western medicine was able to superimpose itself beginning in the nineteenth century (Neuman & Lauro, 1982). This imposition of a foreign medical system was to some extent encouraged by the successive governments of the time. For example, in 1929, the Central Committee for Public Health in the Kuomintang government presented a motion that was aimed at eliminating traditional Chinese medicine (Jingfeng, 1988). This motion even suggested concrete procedures which would include the following:

- # to set a deadline for registering old-style physicians, and to prohibit medical practice without permission or license;
- # to change the training methods for traditional Chinese physicians;
- # to monitor the publication of news related to Chinese medicine, and to prohibit advertising;
- # no school was allowed to establish a programme to train practitioners of traditional medicine;
- # a special license would be given to physicians of traditional Chinese medicine permitting their practice for 15 years only (Jingfeng, 1988).

In the years immediately following the Chinese Revolution, Mao Tse-Tung and his government recognized the need to develop an adequate health care programme for the masses and recognized that some sort of linkage of Western and traditional medicine would improve the quantity and quality of health services. Western oriented medical practitioners were instructed to do a course in Chinese medicine after which they would be transferred to rural service for one year. On the other hand, traditional doctors were required to serve in some hospitals and clinics (Neuman & Lauro, 1982). Mao Tse-Tung's initiatives were welcomed by the traditional Chinese medical practitioners and other stake holders. In 1955, the Chinese Medical Journal which had been largely silent on traditional medicine since its inception, published a few challenging pages:

"We must also fully realize that our ancient cultural heritage is the fruit of the genius and the creative labour of the Chinese people, and that many of our contributions to culture are worth preserving and developing ... If only we could enlarge the scope of our studies in Chinese medicine, rediscover the hidden treasures in our ancient science and art of healing, and make them available to the people, great achievements could result" (Chinese Medical Journal, 1955, cited in Bibeau, 1985, p.940).

In line with Mao Tse-Tung's pronouncements, the government of the People's Republic of China has attached great importance to traditional Chinese medicine (Pei, 1983). This was demonstrated when the Ministry of Public Health set up a national bureau of traditional medicine that was duplicated in the form of departments of traditional medicine at the provincial and municipality levels. A policy framework was put in place to guide the national bureau. The main points of the policy are as follows:

- # to strive to inherit, develop, systematize and raise the level of traditional Chinese medicine;
- # to unite and rely on traditional Chinese doctors so as to give full effect to their initiatives;
- # to organize ways for Western-trained doctors to learn and study traditional Chinese medicine;
- # to modernize traditional medicine and pharmacology gradually;
- # to develop traditional Chinese and Western medicine in a planned and rational way;
- # to protect, utilize, and develop the resources of Chinese medicinal herbs (Pei, 1983).

Since this enabling government policy was put in place, a number of positive developments have been noted. In the medical schools, the curriculum has been structured in such a way that it includes both the modern scientific subjects and indigenous medical courses like acupuncture (Neuman and Lauro, 1982). In the countryside, traditional medical practitioners have been identified and their practices modified to include modern hygiene and scientific knowledge (Bannermann, 1983; Jingfeng, 1988; Pei, 1983).

8.2.3. Ghana

Before British colonial rule, indigenous healers in Ghana were the sole source of health care delivery. This situation was changed in 1878 when the colonial government passed legislation that was aimed at marginalising indigenous healing whilst at the same time establishing a public health service based on Western medicine (Warren, 1986). After independence, Kwame Nkrumah and his government initiated moves that were aimed at giving official recognition to indigenous healers as providers of a health care service. As a first step in this direction, indigenous healers were encouraged to organize themselves into a unified national association. Subsequently, the Ghana Psychic and Traditional Healers Association (GPTHA) was formally inaugurated in 1969 and expanded to include priest and priestess healers in 1973. The objectives of GPTHA are as follows:

- # To promote and encourage the study of herbalism and psychism in Ghana and Africa as a whole in its application to public health and allied fields;
- # To support and protect the conduct, status, and interest of psychic and indigenous healers, to repress malpractices, and to decide on all questions of a vocational and professional nature affecting psychic and indigenous healers for the common good;
- # To consider all matters affecting the interests of psychic and indigenous healers and to initiate and watch over, and if necessary petition the government on general and specific measures affecting psychic and indigenous healers and to effect changes of law affecting members of the association;
- # To provide a central organization in Ghana for research into traditional medicine and to cooperate with Ghana Medical Association;

- # To establish clinics in all the regions for the treatment of those diseases and ailments which Western medicine has not found cures for and to treat common diseases alongside the orthodox practitioners; and
- # To do all things that are incidental or conducive to the attainment of the above objectives (Warren, Bova, Tregoning & Kliewer, 1982).

The second step towards official recognition of indigenous healers came with the establishment of the Centre for Scientific Research into Plant Medicine. Led by Dr. Oku Ampofo, a western trained medical doctor, this centre had the following objectives:

- # To conduct and promote scientific research into plant medicine;
- # To cooperate and liaise with the Ghana Psychic and Traditional Healers Association, research institutions and commercial organizations in any part of the country on matters of plant medicine;
- # To ensure the priority of drugs extracted from plants;
- # To undertake or collaborate in the collation, publication, and dissemination of the results of research and other useful technical information; and
- # To establish, where necessary, botanical gardens for medicinal plants (Twumasi & Warren, 1986).

During the decade of the 1970s several large scale health projects which included activities designed to improve the skills of traditional birth attendants were initiated with international donor assistance. These included the Danfa Project in the Greater Accra area funded through USAID, the BARIDEP project in the Kintampo District funded by WHO and SIDA, and a variety of UNICEF-funded training projects (Warren et al, 1982). Due in part to the success of these projects in working with traditional birth attendants, the PRHETIH (Primary Health Training for Indigenous Healers) project was initiated in 1979 in Techiman District and expanded to include all categories of indigenous healers. The PRHETIH project consists of a training course for indigenous healers at a local hospital, geared to improving basic health care understanding, yet structured to allow responsive input from the trainees. The PRHETIH project is reported to have served as a successful pilot project which has led to the establishment of

similar projects in other districts (Dauskardt, 1990; Twumasi & Warren, 1986; Warren et al, 1982). In addition to its considerable popularity in Ghana, the PRHETIH project has had international exposure and has been used as a model within the Traditional Medicine Programme of the World Health Organization (Warren, 1986).

8.2.4. Zimbabwe

Before Zimbabwe became independent in 1980, the activities of indigenous healers were despised by the colonial governments which, for many years, tried to discourage people from utilizing the services of these providers of an alternative health care service (Chavunduka, 1986). When Zimbabwe became independent in 1980, the new government expressed a favourable attitude towards indigenous healers. In fact the Zimbabwe National Traditional Healers Association (ZINATHA), the only national association officially recognized by the government, was established in July 1980, just a few months after the country's first democratic elections. Significantly, the first meeting of this association was organized by the first Minister of Health in the democratically elected Zimbabwean government. The aims and objectives of ZINATHA are as follows:

- # To unite all traditional healers into one body;
- # To promote traditional medicine and practice;
- # To promote research into traditional medicines and methods of healing;
- # To promote training in the art of herbal and spiritual healing;
- # To co-operate with the Ministry of Health; and
- # To preserve and promote African culture (Chavunduka, 1986).

After facilitating the establishment of the national association of indigenous healers, the Zimbabwean government started preparing legislation that would provide for the official recognition of the practitioners of traditional healing. Indigenous healers were legally recognized by the government of Zimbabwe in 1981 when an Act of Parliament known as the Traditional Medical Practitioners Act (No 38 of 1981) was passed (Chavunduka, 1986). The Act established a council known as the Traditional Medical Practitioners Council. Section 3(2) of the Act provides for the following functions of the Council:

- # To supervise and control the practice of traditional medical practitioners;
- # To promote the practice of traditional medical practitioners and to foster research into, and develop the knowledge of such practice;
- # To hold inquiries for the purposes of this Act; and
- # To make grants or loans to associations or persons where the Council considers this necessary or desirable for, or incidental to, the attainment of the purposes of the Council (Chavunduka, 1986).

Despite the enabling legislative framework, there are a number of ideological and administrative problems that are associated with this move. For example, at an ideological level the major area of conflict between indigenous and Western trained health practitioners is the subject of witchcraft (Chavunduka, 1986). Whilst indigenous healers are of the view that witchcraft exists, Western trained health practitioners regard such a belief as socially divisive and not in keeping with the scientific notions of what causes ill health. Some of the administrative problems associated with the official recognition of indigenous healers in Zimbabwe include the following: First, though there is official recognition of indigenous healers, the government does not provide funding to the Traditional Medical Practitioners Council or the Association. Instead, the Act only provides for the Council to collect fees from the members of ZINATHA to assist in the running of the Council (Chavunduka, 1986). Second, the referral system between hospitals and indigenous healers is not well established. In most cases, the Western trained health practitioners are reluctant to refer patients to indigenous healers (Freeman & Motsei, 1992). Third, it is indicated that medical schemes at present are not prepared to pay indigenous healers for any claims that they may want to make (Chavunduka, cited in Northern Province Department of Health and Welfare, 1997). In addition to non-recognition by medical aid schemes, many companies and institutions still do not want to recognize medical certificates that are issued by indigenous healers.

8.3. The position of indigenous healing in South Africa

8.3.1. Research findings

In the light of the calls for and moves towards collaboration of indigenous healers and Western oriented health practitioners, a number of studies have been done in many African countries so as to canvass the attitudes of various stakeholders towards this significant policy initiative. In a study that sought to investigate the attitudes of women towards traditional birth attendants in one region of Botswana, Chipfakacha (1994) found that 81% of the women who participated in the study positively rated these traditional midwives. Furthermore, it was found that 90% of the respondents preferred a form of collaboration between the TBAs and western trained health personnel. An attitudinal study of western doctors and traditional healers in Nigeria indicated that the majority of doctors felt that traditional healers should work in government facilities, albeit under the supervision of allopathic medical practitioners. Another study that was also done in Nigeria found that the majority of Western trained nurses believe that traditional healers are effective even though the effectiveness was felt to vary with the specialization of the healers (Odebiyi, 1990). Forty four percent (44%) of these nurses further favoured formal collaboration between practitioners of the two health systems. In a study that was done in Swaziland, Upvall (1992) found that the majority of nurses in rural (mission and private) hospital practice perceived collaboration between indigenous healers and western trained health practitioners positively. These positive perceptions were found to differ with the ambivalent or negative responses given by government nurses in the urban settings.

In South Africa a few studies have also been done to canvass the attitudes of consumers (Edwards, 1986; Farrand, 1984; Freeman, Lee & Vivian, 1994), western trained health practitioners (Freeman, 1992), and indigenous healers (Bodibe, 1989; Sodi, 1987) in the light of national and international voices that have called for the recognition of indigenous healing. In a study that investigated attitudes of Black South African psychiatric patients towards traditional healers, it was found that an informal model of treatment that depends on both Western and traditional care was preferred by the respondents (Farrand, 1984). Treatment in this kind of model is a two-stage process in which the sick person first goes to a Western doctor to get his

sickness cured, and then goes to a traditional healer to determine and alleviate the cause of the illness. In a fairly recent study that sought to obtain the attitudes of patients in a rural hospital towards indigenous healers, Muelelwa, Sodi and Maake (1997) found that 70% of the respondents would prefer to consult medical doctors and indigenous healers working together. Furthermore, 74% of the respondents indicated that they could consult indigenous healers if these alternative health care providers could be allowed to work in hospitals.

With regard to the attitudes of indigenous healers towards collaboration with Western trained health practitioners, Maake, Muelelwa and Sodi (1997) found that 75% of nurses in one rural hospital in the Northern Province perceived indigenous healers as helpful to the community. Furthermore, a significant number of nurses (i.e. 77%) felt that indigenous healers and Western trained health professionals should engage in joint health programmes. Interestingly, the study also found that 55% of the nurses at times do consult indigenous healers when they have problems. Whilst the above findings indicate a positive rating of indigenous healers by nurses, a study by Hopa, Simbayi and Du Toit (1998) give a different picture. In a study that sought to investigate the perceptions of indigenous healers and Western trained health professionals towards collaboration of the two health care systems, Hopa and his colleagues found that Western trained medical doctors tended to harbour negative attitudes towards indigenous healing. In contrast however, traditional healers were found to be positive about the Western medicine including the suggestion about integration of indigenous and Western oriented health care systems.

8.3.2. Official government position

In 1994, the African National Congress (the majority party in the South African Government of National Unity) unveiled its National Health Plan which made provision for the recognition of traditional healers. To quote from the document:

"Traditional [indigenous] healing will become an integral and recognized part of health care in South Africa. Consumers will be allowed to choose whom to consult for their health care and legislation will be changed to facilitate controlled use of traditional practitioners" (African National Congress, 1994, p.55).

It is this broad policy pronouncement that has influenced the South African government to make provision for the utilization of indigenous healers in primary health care (White Paper on Health, 1997). The White Paper further provides for the exploration of possibilities regarding the regulation and control of indigenous healers. In addition it is suggested that criteria outlining standards of practice and an ethical code of conduct of traditional healers should be developed to facilitate registration. Where traditional birth attendants are utilized, they should be educated and supported by the public health sector.

In response to this enabling government policy framework, the National Select Committee on Social Services conducted countrywide public hearings on traditional medical practitioners during May and June 1997 (Health Study Group, 1997). The public hearings, which were held in all the provinces except North West and Northern Cape, focused mainly on three crucial issues which are:

- # Statutory Council for Traditional Healers: The aim here was to look at the desirability of a regulatory council that would determine policy on matters like ethical standards, research code, standards of training, safety, and discipline of the profession.
- # Medical certificates by traditional healers: In this case the issue of whether or not employers should recognize medical certificates issued by traditional healers to their patients would be explored.
- # Medical aid (health insurance) access by traditional healers: Issues relating to the possible utilization of health insurance by people consulting traditional healers would be explored.

Preliminary results of the hearings as contained in a draft report of the National Select Committee on Social Services (1997) could be summarized as follows:

- # All interest groups in general agree that a statutory body for traditional healers is necessary;
- # The interest groups agree that medical certificates issued by traditional healers to their patients should be recognized by employers; and,
- # Traditional medical practitioners should have benefits from existing medical aid schemes.

Whilst national legislation on traditional healing is being prepared, some provincial governments are busy consulting with traditional healers so as to work out specific frameworks for collaboration based on regional realities. For example, the Northern Province Department of Health and Welfare currently holds monthly meetings with a representative association of traditional healers which is known as Northern Province Traditional Doctors Association (Northern Province Department of Health and Welfare, 1997). This traditional healers' association was formed when eleven associations of traditional healers in the Northern Province merged in response to the provincial government's willingness to communicate with only one representative structure (see Appendix E for a draft constitution of Northern Province Traditional Doctors Association).

8.3.3. Organized traditional healers associations and other voices

At present, there are many associations that register and represent (or claim to represent) indigenous healers in South Africa (Health Study Group, 1997). Kale (1995) identifies a number of these associations which include, among others, the Association of Traditional Healers of Southern Africa, the Congress of Traditional Doctors of Southern Africa, the African Dingaka Association, and the African Skilled Herbalist Association. According to Zungu (1992), the Chairperson of South African Traditional Healers Council, his organization had in 1992 a total of 150 affiliate associations that represented a total membership of 145 000 traditional healers. With regard to the control of members, Zungu pointed out that his council registers new members only if they have been tested for competence and genuineness by his council's Ethics and Qualifications Committee which will then issue out computerized cards and final certificates to practice. On the question of whether or not indigenous healers should be officially recognized, Zungu said:

"... a lot of correspondence has been sent [to government] applying for recognition and the removal of all discriminatory laws which forbid the recognition of traditional healers. We have requested that an independent body be set up to register traditional healers. This, we have argued, should be a separate council not integrated with western doctors. This council shall make recommendations to the government as deemed necessary. It must not be westernized but fit into the pattern of Africa. If it is westernized it will lose its

flavour and tradition" (Zungu, 1992, p.26).

Whilst there are calls for the official recognition of indigenous healers, the Health Study Group (1997) identifies a number of problems that are seen to result from the existence of numerous traditional healers associations. First, every association regards itself as the only representative voice for all the indigenous healers in the country. This situation is bound to lead to rivalry between the various associations as each one of them will claim to be the only legitimate body that represent the interests and aspirations of indigenous healers. In addition, this situation will pose a problem for the government as it will be difficult for policy makers to know which representative organization to talk to. Second, the existence of many indigenous healers associations implies that there are separate codes of conduct for traditional healers. This situation makes it difficult at present to apply uniform ethical and regulatory measures to the practice of indigenous healing. Third, the current arrangement for the practice of indigenous healing makes no provision for consumers to lodge complaints or to report cases of misconduct in the event such grievances are raised against a practising indigenous healer. Similarly, one indigenous healer has no recourse against a colleague for improper or unprofessional conduct.

Apart from the government and the representative traditional healers associations that are busy preparing for the official recognition of indigenous healers, there are other stakeholders who are making their unique contributions in this direction. The Departments of Psychology at the Universities of Venda and Zululand do offer courses on indigenous healing to their postgraduate students (University of Venda, 1997; University of Zululand, 1997). In both cases the general aim of the courses is to introduce students to the principles underlying South African indigenous healing systems. In 1997, the Medical Research Council joined forces with the University of Cape Town and the University of the Western Cape to establish a research group that would focus on traditional medicines (Medical Research Council, 1997). The main aim of this research group (under the guidance of Professor Peter Folb of the University of Cape Town's Department of Pharmacy and Professor Peter Eagles of the School of Pharmacy at University of Western Cape), would be to create a comprehensive traditional medicines database for East and Southern Africa for use by indigenous healers, health workers at primary health care facilities, policy

makers, drug regulatory authorities, the pharmaceutical industry, and the public. The research group would work closely with indigenous healers to collect medical and botanical information on indigenous medicinal plants and to use this knowledge to set safety standards regarding herbal remedies. In line with these developments, Eskom Medical Aid now recognizes indigenous healers (The Argus, 08 February, 1997). In this particular case, each employee is given a voucher of R50 per month which could also be used by members of the family to consult indigenous healers. There will be a need for studies in the near future to establish whether or not these initiatives by Eskom and other stakeholders are viable before far reaching policy suggestions can be made.

8.4. Way forward

8.4.1. Linking indigenous and Western healing systems - prospects and problems

(a). Debates in favour of indigenous healing: Several arguments have been raised in the literature about the prospects of indigenous healing. Three such arguments will be identified and briefly discussed in this section. First, the most compelling argument in favour of indigenous healers is advanced by those who hold the view that Western health care providers available in the Third World countries can not adequately address the health needs of the majority of the people in those countries. For example, Neuman and Lauro (1982) estimated that up to 80% of the population in developing countries had little or no access to basic modern health services. Whilst the figure estimated by Neuman and Lauro may have changed as more developing countries are trying to improve their modern health care services, there are indications that even in the 1990s there are still fewer modern health care providers to address the health needs of these communities. In South Africa, for example, this great shortage of modern health care providers is illustrated by Freeman and Motsei (1992):

"At present in remote areas and in the urban townships, many people turn to traditional healers in time of sickness, and for them primary health care may be synonymous with traditional medicine. For the foreseeable future at least it would seem that the traditional healers will continue to offer greater accessibility" (p.1186).

According to Kale (1995) about 200 000 indigenous healers practise in South Africa, compared with about 25 000 doctors of modern medicine.

Second, there have been persistent claims that indigenous medicines have some positive medicinal properties. In his article entitled "Ethnomedical Science and African Medical Practice", Matthe (1989) illustrates how pharmacognosy (a pharmaceutical science dealing with the source, preparation, and dosage of drugs) has significantly contributed to Western science's understanding of indigenous medicines. One of the most important discoveries made by this branch of pharmaceutical science is the finding that both Western and indigenous medicine make use of drugs that have hallucinogenic, anaesthetic, anticholinergic, anticoagulant, and analgesic properties. Matthe illustrated this point by indicating that Isikenama (an indigenous African herb) which is used by indigenous healers as a blood purifier and cough remedy, has the same pharmacological properties as the blood rot (common name) or *Sanguinaria canadensis* Linne (botanical name) which is both an expectorant and emetic. Another example that Matthe gives is that of a herb known as Isibaha which is used by South African indigenous healers also as a cough remedy. This herb has been found to have some pharmacological properties as the white pine bark which is found in the United States and Canada. Other optimistic claims about the positive pharmacological properties of indigenous herbs have also been made. For example, in a major investigation that was started in 1973, Noristan Laboratories (one of the leading international pharmaceutical companies), tested 350 herbs that are used by indigenous healers in South Africa (The Sunday Times, 07/11/1993). Eighty percent of these herbs were found to have some medicinal properties.

Third, several studies have indicated that traditional birth attendants (TBAs) do offer a valuable service in terms of primary health care. In a study done in the Kalahari region of Botswana, Chipfakacha (1994) found that the majority of women of child bearing age prefer TBAs instead of Western trained medical personnel. Whilst most of these women preferred to give birth at home because of the indigenous medicines and abdominal massage they receive from TBAs, there were others who felt that traditional home deliveries were safer and more convenient. Still others were found to be more reluctant to entrust the sluicing of the placentas and other products of conception to "strangers" such as nurses. Chipfakacha's study further indicate that 90% of the respondents preferred collaboration between TBAs and Western trained health professionals. Several governments in the developing countries have developed policies

that make provision for the utilization of traditional birth attendants in view of their success as midwives (Dauskardt, 1990; Isenalumbe, 1990; Maclean, 1986;).

(b). Debates against the use of indigenous healing: The first argument against indigenous healing is upheld by those who are of the view that some of the procedures used by indigenous healers are harmful. One of the most vociferous adherents of this position is Dr Nthato Motlana (one of the most successful medical practitioners and influential Black businessmen in South Africa). In one of his attacks on indigenous healers, Motlana made his point very clear: "Most of it (traditional medicine is based on superstition, meaningless pseudo-psychological mumbo-jumbo which is positively harmful" (Motlana, cited in Sodi, 1996d, p.8). Four years later in a public debate on South Africa's future health policy, Dr Motlana reiterated his rejection of indigenous healing: "I pray and hope that the day never dawns in my life when we are going to throw our health services into the hands of those people (Motlana, cited in Sodi, 1996d. p.8). In his submission to the Gauteng legislature during public hearings on traditional medicines, Motlana recently continued to express his strong views against indigenous healers:

"There are many people who would want us to continue to believe in mumbo jumbo while the West moves into CAT scans and advanced sonars for diagnosis. They want us to believe that the dried-up bones of a monkey's ankle can provide us with a diagnosis" (The Sunday Times, 08/06/1997).

Regardless of how Dr Motlana's statements are interpreted, his reservations about indigenous healing are shared by many others. For example, Green and Makhubu (1984) have warned about the dangers of induced vomiting - one of the methods commonly used by indigenous healers. These authors argue that indigenous healers at times administer herbal preparations that may induce vomiting which may turn out to be very deadly in patients who have got weaker hearts.

Secondly, other authors have pointed to the political and economic dangers that may be associated with moves to officially recognize indigenous healing in the developing countries. Kottler (1988) argues that any move to recognize indigenous healing will only serve to provide a means for the Western health practitioners to monitor and control this alternative form of health care. This will happen because, in her view, the modern health sector is threatened by indigenous

healing. In other words, any attempt by the modern health sector to get closer to indigenous healers will be a political ploy calculated to tame and ultimately emasculate indigenous forms of healing. Another political danger in recognizing indigenous healers is raised by Freeman and Motsei (1992) who argue that such a move will perpetuate the status quo of health care delivery in South Africa. These authors point out that for many years the South African national health care system has favoured a minority section of the population thus leaving large areas under-served. The move by government to collaborate with indigenous healers will provide legitimacy to these health practitioners and, in a way thus give an excuse for the government not to provide adequate modern health care facilities in these under-served areas. Korber (1990) identifies some economic problems that will arise if indigenous healers are recognized. She argues that this move would imply some kind of state assistance which suggests that the meagre resources allocated towards promoting and subsidising modern health care systems would be further divided. Such a move could, in Korber's opinion, financially boost indigenous healers while crippling the modern health care system. Related to this potentially undesirable situation, an antagonistic relationship between indigenous healers and modern health care practitioners would develop as these two groups will have to compete for the meagre financial resources.

Thirdly, other authors have pointed to practical difficulties that will be associated with a move to recognize indigenous healing. For example, Freeman and Motsei (1992) identify two such difficulties. First, compared to Western medicine with its clear guidelines for registration, indigenous healing does not have an official and universal system to determine qualifications. This would pose a problem for the government in determining the appropriateness of the indigenous healer's qualifications and the inclusion-exclusion criterion that should be applied. Second, the existence of many associations that claim to represent indigenous healers in South Africa only serves to complicate the issues. Such a plethora of organizations will make it difficult for health planners to know which group/s register bona fide indigenous healers. Third, indigenous healing is seen to lack a scientific basis. The argument here is that the lack of commonality in terms of epistemology between indigenous healing and Western medicine will make collaboration between the two systems difficult. This sentiment was strongly expressed by Professor Heyl who, in his capacity as a representative of the South African Medical and Dental

Council (now known as Health Professions Council of South Africa) at a conference once said:

"We just simply do not know enough about the practice of the traditional healer to really assess his value ... Council [South African Medical and Dental Council] steeped as it is in the scientific method and a quest for more knowledge and better skills to create a sound basis for medical practice, can not condone such haphazard and unscientific procedures" (Heyl, 1992, pp.27-28).

In my view, the above cautions are important to consider. They highlight the fundamental problems which will attend any collaboration or integration of the two health systems: namely, a modern medical system of knowledge and practice validation set against a traditional system which uses a different cosmology and rules for practice and treatment.

8.4.2. Linking indigenous and Western healing systems - the national options

In one of its many technical reports, the World Health Organization identified four levels at which action could be taken by developing countries to engage the services and skills of indigenous healers (World Health Organization, 1978a). These are international, national, professional, and consumer levels. Judging by the reports that indicate that the majority of people in the developing countries make use of indigenous healing services (Health Study Group, 1997), it does appear that the services of indigenous healers are already engaged at the consumer level in these countries. At the international level, the WHO has through its various projects and reports (see World Health Organization, 1973; 1975; 1978b for example), tried to provide a broader framework for this collaborative effort between indigenous and Western healing systems. Whilst it appears relatively easy to engage indigenous healers at both the consumer and international levels, the same does not seem to hold in the case of professional and national levels. According to Stepan (1983), there are four options that can be considered by governments in the developing countries vis a vis traditional medicine. The four options are: monopolistic relations, tolerant relations, parallel relations, and integrated relations.

(a). Monopolistic relations: In this case only the Western health care system is give legal rights to practice. All forms of alternative health care would thus be prohibited. Immediately after attaining independence in 1975, Mozambique followed this route by officially barring all forms of indigenous healing as these were seen as unscientific, backward and dangerous. This decision which was politically sound in terms of the socialist ideals of the FRELIMO government became difficult to uphold for two main reasons. First, the majority of Mozambicans ignored the prohibition and continued to consult indigenous healers (Jurg & Marrato, 1992). Second, the opposition guerilla army of Mozambique National Resistance (RENAMO) is reported to have made greater use of indigenous healers in regulating daily military life (Honwana, 1997). With every successful military operation by RENAMO, the status of indigenous healers was thus enhanced. In view of these developments, the government lifted the prohibition and instead introduced a piece of legislation that provided for the registration of indigenous healers. Since this prohibition was lifted, the Ministry of Health in Mozambique has made provision for indigenous healing to exist as a separate and parallel self regulating health service (Jurg & Marrato, 1992).

(b). Tolerant relations: This option provides for a laissez faire approach towards indigenous healers. In other words, indigenous healers in this case are free to work and to receive payment for their services even though their practice would not be officially recognized by the government. In Africa, a number of countries (among others, Uganda, Burundi, Kenya, Central African Republic) have preferred to follow this route (Kale, 1995).

(c). Parallel relations: This option provides for official recognition and assistance by government of both Western and indigenous healing systems. The implication here is that by recognizing indigenous healers and allowing them to practice side by side with Western health care providers, the government is effectively acknowledging that indigenous healing has an important role to play in health care delivery. As was indicated in this chapter, Zimbabwe is one of the African countries that have followed this route immediately after independence. According to Chavunduka (1992) this form of cooperation promotes mutual respect and understanding between the practitioners of modern health and those engaged in indigenous forms of health care.

Other African countries that have followed this route include the United Republic of Tanzania and Zaire (Kale, 1995) and Mozambique (Jurg & Marrato, 1992).

(d). Integrated relations: This option provides for a merged and hybrid health care system that incorporates features of both Western and indigenous healing. The People's Republic of China, as indicated elsewhere in this chapter is one of the countries that have followed this route. There are a number of conflicting reports about the outcome of this approach. For example, whilst Pei (1983), and Jigfeng (1988) herald this health care "experiment" as a success, Bibeau (1985) is of the opinion that this arrangement compromised the sophisticated theoretical knowledge of Chinese medicine as traditional Chinese doctors were required to accept scientific methods and to be supervised by Western-trained doctors in their acquisition of the necessary technical skills. For Abbot (1988), the compromised position of Chinese medicine vis-a-vis Western medicine would be interpreted as the "besting of rival professions" (p.30) in a perpetual dispute by professions for jurisdictional boundaries.

8.4.3. A viable option for South Africa

A full study of the complexities and implications of linking traditional and modern systems would require a comprehensive dissertation. This is beyond the scope of the present study. The present discussion will be limited to a brief sketch of some possible developments which might be suitable in the South African situation. In this discussion, we need to remember that in Western models, psychological interventions and theory are largely split off from matters to do with the body, while in traditional African medical systems they are not.

(a). Western psychological and African indigenous healing: In this section a few central points emerging from the different chapters of this thesis are distilled and presented so as to inform the suggestions that I will make regarding collaboration between indigenous healing and modern health care in South Africa. First, in line with the argument raised by Foucault (1980b) in an earlier chapter of this thesis, the ascendancy of psychology as a scientific knowledge system to a monopoly truth status has led to the relegation of alternative knowledge systems that have also sought to explain the human condition. Like in other parts of the world , psychology in Africa

has over the years become one of the "technologies of power" that has been successfully used to disqualify and silence African indigenous theories about human behaviour, illness, and healing. In line with a call made by Foucault (1980b), there is a need to challenge the power relations between Western psychology and indigenous healing systems. Viewed from this angle, psychology's privileged position in the explanation of human behaviour in Africa should be questioned. In addition, there is an need to legitimize indigenous healing as one of Africa's knowledge systems that need to be developed.

Second, the embeddedness of every knowledge system in a particular cultural environment raises questions about the appropriateness and applicability of Western psychological theories in different cultures of the world. Psychology as a knowledge system is a cultural product of a particular society whose social and ideological realities will shape its development and orientation. As Gergen (1985) has pointed out "The terms in which the world is understood are social artifacts, products of historically situated interchanges among people" (p.267). For example, the diagnostic labels that are used in Western psychiatry and psychology are realities insofar as they are constructed by and maintained within a social system that regards voice hearing as one of the manifestations of a psychopathological process. On the other hand, in many African societies voice hearing may not be construed as a manifestation of psychopathology, but as an ability by the voice hearer to interact with divinity.

Third, Kleinman and Sung's (1979) distinction between disease and illness could be usefully applied in making suggestions about the future role of indigenous in health care delivery within an African context. Psychology and medicine have been heavily influenced by the medical model of health and disease. This model views conditions of ill health as resulting from a specific, identifiable cause originating inside an individual person. Inevitably, traditional psychological treatment approaches focus on a disease that is perceived to be within a person. According to Kleinman and Sung (1979), in many non-Western therapeutic systems treatment is aimed at both a disease (the pathogen inside a person's body) and the illness (i.e. the psychosocial and cultural responses to disease). In line with Kleinman and Sung's model, the present study found that indigenous healers' therapeutic approaches are aimed at both the disease

(for example "bolwetsi bja go wa" which is believed to be inside the patient's body) and the illness (that is, the personal and social problems it gives rise to). This holistic orientation of indigenous healers will thus need to be accommodated in any dispensation that would seek to give official recognition to indigenous healers in South Africa.

Fourth, in the present study it was found that indigenous healing is a culturally meaningful process that can be divided into three phases, namely the initial phase, middle phase, and terminal phase. During each phase, there are certain therapeutic tasks that need to be performed in order for the process to move forward. On the basis of this finding, it is argued that the process of indigenous healing has several similarities with Western psychotherapy. However the two therapeutic traditions appear to differ in terms of the content that needs to be changed. For example, whilst a Western trained therapist may regard a certain cluster of symptoms as indicative of a depressive episode that needs pharmacotherapy and psychological intervention, an indigenous healer on the other hand may regard a similar clinical picture as "senyama" (bad luck) that would need the administration of medicines and the performance of certain rituals.

(b). Registration of indigenous healers: While there are clearly broad similarities between Western and African traditional models of operating, there are certain central differences, particularly at the epistemological level, which suggest that indigenous healers should be masters of their own destiny. In other words, registration and control over indigenous healers should be in the hands of the indigenous healers themselves as Western standards of regulation may not be appropriate to indigenous healing. If indigenous healers are to become masters of their own destiny, they might consider setting up a national body (in the form of an association or council) to determine ethical and training standards and to register, control and discipline indigenous healers. Furthermore, such a national body would liaise with the government for the purpose of encouraging provincial health departments and district health units to work closely with indigenous healers so as to provide a holistic health service to the local community. It is at such local levels that specific forms of collaboration between indigenous healers and modern health practitioners would be worked out in order to accommodate the unique interests, local cosmologies and cultural peculiarities of indigenous healers and communities in each province.

(c). Co-operation with the modern health sector: Having introduced the four policy options (i.e. monopolistic, tolerant, parallel and integrated relations) in an earlier section of this chapter, I will now consider the appropriateness of each of these possible policy directions in a South African context. In this regard, I will mainly identify the problems associated with each option and finally argue in favour of the parallel system which I regard as the most appropriate route to be followed by South Africa.

(i). Monopolistic relations: Even though this option suggests that the government will only direct its resources to the improvement of the modern health sector, there are a number of problems that are likely to emerge. First, making the traditional health system illegal would imply that a certain portion of police resources would be required to enforce the decision - a move that would most likely be interpreted by the majority of South Africans as a return to colonial policies. Second, given the democratic dispensation in South Africa and the fact that indigenous healers are consulted by the majority of people in this country, legislation against indigenous healing would be difficult to pass through parliament at the moment. Third, making indigenous healers illegal would drive them underground and thus make it difficult for the government to adjudicate in the case where a consumer may want to lodge a complaint against a traditional health practitioner.

(ii). Tolerant relations: Whilst indigenous healers are free to practice if legally tolerated, this option implies that the government will only make resources available to support the modern health sector. Such an option which has hitherto been followed by South Africa is likely to perpetuate the status quo (i.e. dominance of the modern health sector). Given the strong transformative orientation of the South African government White Paper on Health (1997), the privileged position of the modern health sector is going to be increasingly challenged.

(iii). Integrated relations: As was pointed out earlier, indigenous healing and Western medicine are premised on different epistemological foundations. These divergent backgrounds would make it difficult to integrate these two health systems. Even in cases like China where the integration option has been followed, there is a concern that indigenous healing has been stripped of its

unique holistic features and reduced to a set of technical skills (Bibeau, 1985). In South Africa, indigenous healing is most likely to face the same problem should this option be contemplated given the powerful position of Western medicine.

(iv). Parallel relations: A number of problems could arise if this policy option is followed. First, indigenous healing and Western medicine in South Africa are not at the same level of development and sophistication. If these two health systems are accorded the same status, modern medicine is likely going to play big brother and thus stifle the development of indigenous healing. Second, the relative advantage of the modern health system is likely to tempt indigenous healers to model their practices upon that of Western-trained health practitioners. Such a situation is likely to be met with resistance by Western-trained health practitioners who may feel that their jurisdictional boundaries are being invaded. Despite the problems associated with a parallel system, it is suggested here that this option could be most appropriate for South Africa to consider at the moment. In order to implement this policy option successfully, the following practical steps are suggested. First, considerable financial resources will need to be made available if the government is serious about researching and supporting indigenous healing. Second, it is proposed that the government set up joint working committees at both national and provincial levels so as to encourage cooperation and to resolve conflicts that may arise between the two health systems. Such joint committees could also be utilized to provide public health education regarding the complementary benefits of the two health systems. Third, at the level of service provision, it is felt that much greater contact be encouraged between the two categories of health care providers whilst at the same time guidelines for referral between the two health systems are developed.

Finally, it must be pointed out that what I have outlined in this chapter is a very limited and preliminary exploration of some of the issues which would need to be taken up if indigenous healers and modern health practitioners are to begin a useful dialogue. There is a need for more research and an open national debate on the links between indigenous healing and a modern medical system in South Africa.

CHAPTER 9

SUMMARY AND CONCLUSION

9.1. Summary of findings

The two main aims of the present study were (i) to do a phenomenological inquiry into the process of indigenous healing as conceptualized by a group of North Sotho indigenous healers, and (ii) to interpret these subjective representations by the indigenous healers so as to develop ideas regarding the links between indigenous healing and modern medicine in forging a new mental health policy for South Africa. The following three themes \ hypotheses, each addressing some aspect of the process of indigenous healing, were consequently generated:

9.1.1. "Go thwasa" is a preparatory step that leads to integration of personality, acquisition of clinical competencies and the attainment of transcendental experiences

Before practising as an indigenous healer, the individual who is perceived to be destined for this vocation will go through an arduous process known as "go thwasa". Believed to be selected by spiritual beings, the "go thwasa" person will first show some pre-training features like unpleasant dreams and some physical or psychological complaints which will at first be commonly felt as ego dystonic. Once these features have been diagnosed as a manifestation of the "go thwasa" experience, the affected individual will become an apprentice under the tutelage of a master indigenous healer. Apart from acquiring the necessary clinical skills, the budding indigenous healer will get an opportunity to work through some of the unconscious conflicts and tensions that will have made coping difficult before the apprenticeship. At the end of the training programme, the affected individual will have developed a more integrated and resilient personality structure that can withstand potential stress and conflicts. In addition, the period of apprenticeship could be regarded as a crucial stage during which the affected individual will be sensitized to access the spiritual dimensions of his life by interpreting dreams and other non-ordinary experiences as messages from ancestors.

9.1.2. Indigenous healers attach culturally congruent labels to clusters of physical and psychological symptoms presented by their clients.

It is evident from the results of this investigation that indigenous healers have evolved a nosological system that helps them to understand, classify, and label clusters of symptoms that are a source of distress to their patients. These diagnostic labels are communicated by the indigenous healer in a language that is understandable and consistent with the patient's cultural world view. On the basis of this finding, the diagnostic labels given by the indigenous healer are thus postulated to serve two main therapeutic functions. First, the interpretation that the indigenous healer gives to what is experienced as a group of nonsensical and distressing symptoms will make the patient feel understood. Second, the diagnostic label and the treatment programme suggested will help allay some of the patient's lingering fears while at the same time raising his confidence in the indigenous healer's effectiveness.

9.1.3. Indigenous healing is a multi-phasic process that is aimed at the client and the total home environment whilst at the same time providing an opportunity for some to access spiritual dimensions of their experience.

The data that emerged from this investigation indicated that the process of indigenous healing could be divided into three phases, each with some essential therapeutic goals that need to be accomplished. During the initial phase, the indigenous healer will seek to establish rapport with the patient who will normally be accompanied by at least one member of his family. Once rapport has been sufficiently established, the indigenous healer will embark on the second therapeutic goal which involves identification of the problem. The second phase, known as the treatment phase, begins when the indigenous healer undertakes to restore good health to the patient by using physical, psychological, and spiritual intervention strategies depending on the nature of the problem. In some cases, the indigenous healer may want to reconstitute the family system so as to deal with the presenting problem. In this regard, the involvement of other members of the family will be desirable during the process of treatment. These encounters with other family members appear to provide an opportunity for lingering family tensions and conflicts to be enacted and resolved in a safer therapeutic environment created by the indigenous healer. Apart from these interventions which appear to be aimed at the individual and the family, the

indigenous healer may, in some cases prescribe the performance of rituals as an appropriate strategy to deal with a problem. In addition to their heavy spiritual content, these ritual performances will be conducted in such a manner that the entire home environment will be targeted as a therapeutic unit. During the terminal phase, the indigenous healer will negotiate for the termination of a therapeutic relationship. Provision will usually be made for follow up assessment and treatment while difficult cases are either referred to other colleagues or to the hospital.

9.1.4. Implications for mental health policy

In view of the complementary and unique role that indigenous healers do play within the cultural context of South Africa, it is suggested that the current national efforts to recognize indigenous healing be vigorously pursued. In terms of the nature of the collaboration between the modern health care system and indigenous healing, it is proposed that indigenous healing be allowed to operate as a parallel self regulating health service. This arrangement could allow each of the two healing systems (i.e. indigenous healing and modern medicine) to develop optimally without having to be unduly influenced by the other. Other specific suggestions that are made include: (a). the establishment of a national body of indigenous healers that will regulate, control, and determine training and ethical standards for indigenous healers. Furthermore, such a national body would liaise with the government for the purpose of encouraging provincial health departments and district health units to work closely with indigenous healers at local levels. (b) the establishment of joint committees at both national and provincial levels comprising of indigenous healers and modern health practitioners for the purpose of adjudicating in the case of disputes related to professional territorial boundaries, and (c) the development of guidelines for referrals between indigenous healers and modern health care practitioners.

9.2. Limitations of the present study

While every effort has been made to adhere to recommended research strategies, there are a number of shortcomings that have beset the present investigation. First, the size of the sample on which the results of the study are based is small for us to make conclusive statements and to generalize beyond the sample itself. As it was pointed out in the methodology section, four

indigenous healers selected on the basis of the known sponsor model (Patton, 1990) were observed and interviewed. While acknowledging the limitations imposed by the sample size, it should however be pointed out that the present study did not seek to make a quantitative analysis of the results. Instead the researcher has explicitly sought to give a qualitative description and interpretation of the process of indigenous healing as perceived by the indigenous healers themselves. The three phase model of indigenous healing and other postulations derived from the results of this investigation should thus be seen as a framework for guiding further studies before conclusive statements can be made.

The second limitation of the present study may have resulted from having to translate the interview data from North Sotho into English before a phenomenological explication could begin. Marcos (1979) has identified a number of errors that are often committed when researchers or clinicians attempt to translate recorded interviews. These errors include omissions, substitutions, and condensations. Although the researcher has proficiency in both the source and target languages, it is fair to acknowledge that it may not have been possible to avoid the above errors at all times.

The third limitation imposed on the present study results from the non-involvement of patients in the sample. It is noted that indigenous healing, like all other forms of therapy, is an interactive process that involves at least two people. By focusing only on the indigenous healers and their experiences of the process, the present study has thus given a one sided interpretation of the process of indigenous healing.

Fourth, the breadth of the research problem in the present study allowed for little depth in certain areas which needed more detailed investigation. For example, each of the three hypotheses generated called for more in-depth analysis than was done in this study. It is for this reason that the findings of this study should be treated as exploratory and thus not offering any concrete solutions.

With the above limitations noted, the following three specific suggestions are made for future research:

- # There is a need to do a more elaborate investigation of the various illness categories and the healing strategies that were identified in this study. It is hoped that such an investigation on the cultural notions of ill health and healing among the North Sotho speaking people would make a contribution to the growing body of knowledge on culture and (mental) health.
- # In order to establish their wider applicability, the three hypotheses generated in this study would need to be investigated further. In this regard, it is suggested that larger and more ethnically representative samples of indigenous healers be put together.
- # There is a need for more interdisciplinary studies to establish, among others, the medicinal, pharmacological, ecological, and psychological effects of the various medical preparations that were identified in the present study. The need to conduct such studies is even more urgent in the light of the current moves by the South African government to officially recognize indigenous healers.

9.3. A final comment

By way of concluding this thesis, I will quote from the work of one African theologian who is of the view that there are many lessons that Western healing systems could learn from indigenous knowledge systems of Africa:

"The latest trend in [Western] psychotherapy is therapy in groups. The clients are grouped together as peers: as one being calls out on another in a relaxed situation they relate to one another and their misinformed, injured psyches are straightened out and normalized by the dynamics of human interaction. The African extended family has long before Western discovery been the arena for such a healing process. The whole African traditional life-style with its age-sets, rites of passage, several generations living together, is built on the principle that 'You cannot be human alone' ... Our humanity finds fulfilment only in community with others" (Setiloane, 1988, p.41).

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my sister-in-law could not conceive. Her failure to conceive was causing a lot of friction in our family as my brother was beginning to blame her for failing to bear him children. One day as I was asleep, my ancestors visited me and instructed me to go and collect some herbs that I would administer to my sister-in-law. When I narrated this dream to my parents the following morning, they just dismissed me and even warned me not to pester them with what they dismissed as silly dreams. I then decided to disobey them and went ahead to explain my dream to my sister-in-law. She was so excited that she literally begged me to do as I was instructed by my ancestors. I went on to collect the herbs as directed. I mixed and administered the medicines to her. After a short while, she did conceive and gave birth to a healthy girl. After that experience, I started having more dreams and ancestral instructions on who I should help. Mind you all these healing activities were taking place before I received formal training as an indigenous healer. It was all just a matter of ancestral guidance. In 1972 I had a strange experience that eventually changed my life. It was just one ordinary day and I happened to go to the nearest river to do some washing. Whilst doing the washing, I somehow lost my consciousness and fell into the water. What exactly happened thereafter is difficult to tell as I only regained my consciousness at home. Shocked by this incident, my parents invited a local priest to come and pray for me. When the priest's interventions did not help, and also upon the insistence of my uncles and aunts, my parents did finally invite one local indigenous healer. On arrival he threw his divination bones and advised that my strange behaviour was an indication of a call to become an indigenous healer. He referred me to another indigenous healer who had a good reputation of training people to become indigenous healers. I went through the training programme and on my return home at the end of 1972, I was a fully fledged indigenous healer.

T: So it took you less than a year to train as an indigenous healer.

J: Yes. To be exact, the training lasted for four months. On the fifth month I was taken home. It took me such a short time to train because my ancestors had already guided me for a long time before the actual training. I would say my training was to a large extent a way of formalizing my status as an indigenous healer.

T: Does it mean that everyone who becomes an indigenous healer has to be sick before they train?

- J: Let me put it this way. A person who is called to become an indigenous healer is not like someone who goes to a driving school to obtain a driver's license. In the case of a driver's license, you simply decide when you feel ready to learn to drive. In our case it is the ancestors who decide on the person who should become an indigenous healer and also when such a person need to undergo training.
- T: What if, say, I develop an interest and approach an indigenous healer to train me without being called?
- J: It is unthinkable in our culture to [train without being called]. Our training is different from that obtaining in Western culture where the medical profession is joined by those who choose to do so. In the case of indigenous healing, you have to be called by the ancestors.
- T: Let us now look at therapeutics. What kind of illness do you specialize in?
- J: I do treat many types of illnesses. In Western medicine there is what they call stroke. In our terminology we refer to this condition as "sefolane". I know how to treat cases of "sefolane", infertility, and various types of venereal diseases. I have also treated a lot of cases of mental illness. In addition, I do train people to become indigenous healers. These days people talk of Aids. My understanding is that this disease is transmitted through sexual contact. If the hospital could give us the opportunity, we as indigenous healers would help treat this condition. Unfortunately the medical professionals do not want to refer their patients to us. If there could be a better referral system between the hospitals and indigenous healers, a lot of Aids victims could be helped before their conditions become chronic. If these doctors could stop being selfish we could both help the people.
- T: After treating a person how do you assess the outcome of your treatment?
- J: There are many ways of assessing [therapy] outcomes in our practice. I will give you an example of how we deal with a mentally disturbed person. Normally such a patient will be brought to us by relatives who will usually complain that he is aggressive, running around, talking irrelevantly, hearing voices, hording, and so on. On arrival here I will consult my ancestors [through the divination bones] to advise me as to the nature of the problem as well as suggesting to me the appropriate form of treatment. I will then follow these guidelines and start treating the patient. To show that the patient is beginning to improve you will see him beginning to "swaba" (to be shy) and to realize that he is shabby and not properly dressed.

I will then send him to the local shop to buy me one or two items. This exercise is intended to establish if the patient is beginning to get his senses back. If he is still disturbed he will fail to follow my instructions. He will come back with the money without the items that he was supposed to buy. On the other hand if his condition is improving, he will come back with the items as instructed. How the patient relates to these simple instructions will give me an early indication of how his condition is progressing. If I am getting satisfied with progress and if the patient is following the instructions, I may decide to send him to town to buy me a number of items. If he comes back with every item as directed I will get the impression that he has improved. You see, the medicines we use are very effective. It takes only a few days before the patient begins to "swaba". Usually it is at this point that I will invite his relatives to my place to come and have their own assessment of the patient. In their presence, I will request the patient to perform certain tasks. A patient who has recovered will start by greeting the relatives and even get into a meaningful conversation with them. He will ask them about how they are doing and how everybody at home is feeling. Normally I will request such a patient to perform certain tasks in the presence of the relatives. After a while, I will ask them to give their own impressions of the patient's condition. They will communicate their impressions to me. All these tasks that the patient is requested to perform are meant to test his ability to relate to the relatives and to judge if his condition has improved. If his relatives are satisfied, I will then start making preparations to send the patient back home. Before this is done, the patient will have to be "hlapiswa" (cleansed) and "thekgwa" (protected). Even before I take [the patient] home, I have to go to his place and "thekga" (protect) the homestead.

T: What is this "go hlapisa" and "go thekga" that you have just referred to?

J: You see, if a person is mentally disturbed, it is like he is deceased. Recovering from mental illness is like coming back from the dead. So we have to "hlapisa" this person to remove the "senyama" (bad luck) or "leswiswi" (darkness). It is like we are removing the heavy yoke from his shoulders and also taking off his "letlalo la ditshila" (dirty skin). Having brought him back and with a new skin, such a person has to be "thekgwa".

T: You did mention "senyama". Would you like to tell me more about this?

J: Certainly. In our vocabulary "senyama" has got many meanings because it is caused by a

wide range of things. It may roughly be understood as darkness or bad luck. For example, if you attend a funeral, you get "senyama". This kind of "senyama" can only be rubbed off by washing your hands before you leave the deceased's home. Failure to do so will lead to a contamination that may be detrimental to the health of your family. A woman who has had abortion or miscarriage is also having "senyama". A man who happens to have sexual contact with such a woman will be contaminated by the "senyama". Such a contaminated man or woman is a hazard to the health of other people, more especially children and livestock. A person who is mentally disturbed is also having "senyama". His body is contaminated. It needs to be cleansed to rid the patient of this contamination. It is as if he is dead because he does not realize that he is out of touch with reality and behaving inappropriately. He may use a container that is leaking to fetch water without realizing that his action is inappropriate. His sense of judgement is gone. He is mentally disturbed. As soon as his condition improves he will realize that his behaviour is inappropriate. In other words, he will begin to be himself and to have a good sense of judgement.

T: So, this "senyama" will have to be removed through "go hlapisa"?

J: Yes. If a person with "senyama" is not cleansed he will never recover. Even if he may stop showing the flagrant symptoms like aggression, he will appear to "swaba" and to show poor eye contact. If we discharge him while he is still in this state, he will fail to relate to others when he gets back home. If he is married, he will be too shy to even suggest having sexual relations with his wife. This may lead to problems as the wife may even be forced by such a situation to take the initiative.

T: It sounds like there are many procedures that have to be followed in the treatment of a mentally ill patient. What is your comment?

J: Yes. After all these procedures that are aimed at the patient have been performed, we have to go to his place to "aga motse" (protect the homestead).

T: Why do you have to strengthen the homestead?

J: We have to do so because it is as if his homestead has been struck by lightning. The homestead has been destroyed and has to be rebuilt in order to be habitable. Obviously we can not take such a person to these ruins. We have to rebuild what has been destroyed and to make sure that the lightning does not strike again. The protected homestead will also make

such a person strong and confident as soon as he gets back.

T: So, you are saying that in your treatment you do not only target the patient. Is this right?

J: Yes. We help everybody in the homestead, including the wife, children and even the livestock and crops. When we say that the person is okay, we are also saying that his home, his children and his belongings are okay. If we do not address the entire home environment, he will get sick again and come back to us. We obviously do not want to see such a situation. So we have to go and fix his place before he is taken back. His relatives will be expected to organize transport for me. On arrival at the patient's home I will perform the necessary rituals and shortly after that I will take the patient home. I will usually give the relatives a period of three to four months to observe the patient at home in terms of how he relates to them. What I have often seen is that the relatives will normally approach me even before the three or four month period has elapsed to thank me for the services rendered. They will often invite me to visit them again and to celebrate the good health that I will have restored to their lives and family. During such visits, I will again spend some time with the patient trying to assess if he has fully recovered.

T: Does it mean that the patient has to go through this process before you are satisfied with the outcome?

J: Yes. When the patient arrives here the first step is always to throw the bones and to establish the nature of his problem. The "ditaola" (divination bones) will always tell me exactly what the cause is and also how I should treat the patient. If it is a problem like mental illness I will advise the relatives to leave the patient in my care until he will have improved. On the other hand, there are problems that may not warrant a patient's stay at my place. In such mild cases I will usually prescribe medication and advise the relatives to come back for follow up treatment after some time.

T: There appears to be a high premium that you place on the divination bones. Can you tell me more about this?

J: Yes. The divination bones are my extra eyes. They will indicate many things to me. From the fall of the bones I can tell everything about the patient.

T: Are there methods of diagnosis other than divination bones?

- J: Yes. There are many other types. The method that a particular healer uses will always be determined by his ancestors. There are other indigenous healers who can arrive at a diagnosis without using the divination bones. For example, there is what we call divination by "moya" (spirit). In this case, the diviner will work like a prophet and tell you what they see. There are still many other diagnostic methods like divination through the use of water and a cloth. There are some indigenous healers who will combine a number of diagnostic methods because they will have been directed to do so by their ancestors.
- T: So the ancestors guide you all the way.
- J: Yes. We are always guided by the ancestors. Just to give you an example, even before you came to visit me I saw that from my dealings with the ancestors. They did indicate to me that somebody special would be coming to pay me a visit. So I was not surprised when you arrived and requested to interview me. My ancestors guide and indicate to me the kind of people who will be coming to see me. If it is a patient who is supposed to be coming to see me, my ancestors will even show me the nature of his problem. When he arrives here I will be ready.
- T: I see.
- J: Everyday before I go to sleep I will sprinkle a little snuff on the floor and talk to my ancestors. I will tell them that as I fall asleep I would like them to come and guide me on how best I should treat my patients. Sometimes they will advice me to review medication for some of my patients and suggest the form of treatment that I will have to prescribe for the patient. I have to follow all these advices.
- T: There is a suggestion that indigenous healers are also witches. Would you like to comment on this?
- J: Right from the beginning, we have been unfairly treated by white people who have always referred to us as witchdoctors. This label has over many years antagonized our relationship with the people we are supposed to serve. The simple truth is that we are not witchdoctors. Some of our people are now beginning to believe these white people and they often appear to be surprised when they see an indigenous healer being successful in life. They tend to forget that as indigenous healers we get paid by our patients. They also fail to appreciate that as indigenous healers we are on duty 24 hours a day as patients visit us any time. The wrong

perception that has been created needs to change. I remember last year there was tension in the area of "kgoshi" (chief) Sekororo. A section of the youth was accusing indigenous healers of being witches. We were all called to a meeting with the youth. I stood up and warned all the youth never to trouble the indigenous healers. I gave them an explanation of what indigenous healers do. I explained to them that indigenous healers perform a lot of valuable functions in the community which, among others, include rain making, treatment of the sick, and acting as special advisors to the "kgoshi". By the end of the meeting all the young people were happy with us. Since then the problem has been resolved. Indigenous healing is part of our culture. We just have to stick with it. There is no way some of us can run away from our responsibility as indigenous healers. Right now, if I happen to get sick I will not just go to the hospital without informing my ancestors first. Failure on my part to communicate with my ancestors before taking such a step may result in bad consequences. For example, if without having informed my ancestors I receive an injection from the hospital, I will develop a lot of complications. Always before I go to hospital or anywhere outside my village, I have to throw a little snuff on the floor and say something like this: " My grandparents, I am taking a trip today, do not be surprised. I would like you to lead me all the way and to bring me back home safely". If this message is expressed, my journey will always be safe.

T: In other words the ancestors are always with you.

J: Yes. Like now as I am talking to you they are guiding me as to what I should tell you. They protect me all the time. That is why I told you last time that there is no one I can trust more than the ancestors.

T: How do you assess if your treatment has been successful?

J: If the patient is an epileptic [and receives our treatment] he will not have the fits any more. If he is mentally disturbed, he will no longer talk to himself. He will no longer fetch water with a basin that is leaking. If it is a person with a sexually transmitted disease we will no longer see him sweating excessively like before. The patient will become sexually active again.

T: Let us focus a bit on mental illness. How do you see the effectiveness of your treatment and how long will you treat such a patient?

- J: Sometimes a person gets sick and stay at home for far too long until his condition has worsened. It becomes too difficult to treat such a patient. On the other hand if a patient is brought to our attention during the earliest stages of the illness, he will not take long with us. Such a patient's chances of recovery will also be much better. If the condition is still acute, the patient may stay with us for 3 days or so. On the other hand, chronic patients will stay much longer with us before they recover.
- T: How will you tell that your treatment is not successful?
- J: It depends on one's experience as an indigenous healer. I have now been working for some years now and I can tell when a patient is not making any good progress. After a week or two of intensive treatment, I may decide to consult my peers for advice if I do not make any positive progress with that particular patient. I will discuss with my colleagues and solicit their opinions on how best to help the patient. Sometimes you may find that the poor progress that the patient shows is related to some problems that do exist at his place. For example, it may be that there is dissatisfaction on the part of the patient's ancestors. If this is discovered to be the case, we will advice the relatives of the patient to perform the necessary rituals. Once this is done you will see the patient's condition improving. Sometimes it may as well be that there is conflict in the family. We have to help extinguish this fire before we can allow the patient to get back home.
- T: Do you sometimes consult other indigenous healers for their opinions?
- J: Yes. I also refer my patients to the hospital if this becomes necessary. If on assessment I get the impression that the patient's condition needs hospital medicines, I will not hesitate to refer the patient. Usually I will advice the patient to come back for my treatment after he will have received the treatment from the hospital. As indigenous healers we are not supposed to treat patients whose conditions are beyond our knowledge. Doing so will invite the wrath of the ancestors. We do cooperate and share our skills with others.
- T: Would you consider collaborating with Western health professionals if this could be made possible by the government?
- J: As indigenous healers, we have always been prepared to collaborate with Western trained doctors for the sake of our people's health. The problem though is that these doctors in the hospitals are not prepared to work with us. We do refer patients to them. Unfortunately they

do not do the same in those cases where they fail. For example, if a person has "sefolane" they will just keep him in the hospital until his condition is such that they will consider amputating the legs. Once the condition spreads to his arms they will go on amputating until the person will loose all the limbs. This is too bad. If such a patient [with "sefolane"] is referred to us early, we can treat the condition without the person having to loose the limbs. If I diagnose "sefolane", say on my patient's left leg, I will first attend to the limb that is not affected in order to stop the condition from spreading. Once I have done that, I will then attend to the affected leg and administer the medicines. Western doctors should stop this cruel tendency of always resorting to amputation. It is fairly easy for us to treat this condition.

T: What is the "sefolane". Could you describe it to me?

J: "Sefolane" is a disease that comes in many ways. You may get it by crossing certain paths that you should not cross. You may be pricked by a thorn that has been doctored by those with evil intentions. You may get bitten by a snake that has been sent as a familiar by the witches. A person with "sefolane" will show a swelling in the limb that has been affected. The swelling will keep on spreading to affect the other limbs and ultimately the whole body until the patient dies. Once this swelling is noticed by Western doctors, they will not hesitate to amputate.

T: How would you describe your work as an indigenous healer?

J: My main duty as an indigenous healer is to help others. There are so many people out there who need help. We have been chosen by the ancestors to help these people. We are not witchdoctors as the white man is saying. If we had the intentions to harm others, where would we get our future clients? It would be as if we are killing ourselves.

T: What is "malopo"?

J: "Malopo" is a condition that is brought to the living by ancestors either as a sign that they are happy or as an indication of their displeasure. Sometimes it may happen that one's grandparents die with a complaint. This will later emerge in the form of illness that will befall members of the family. Once the illness has been diagnosed, the afflicted person must perform the necessary rituals that will culminate in a "malopo" dance.

T: The shaking and restlessness of a "malopo" person that is often noticed. What is it that causes the shaking?

J: The shaking and restlessness is an indication that the person feels the pain [and that his body has been invaded by the ancestors]. The spirits of the possessing ancestors have taken over the control of such a person's body. By taking over the body of the possessed person, the ancestors are trying to find a way of making their needs and wishes known to the members of the family. It is like they communicate with the rest of the family through the possessed person. The thing about ancestors is that you can not ignore them. One thing interesting to note about "malopo" is the fact that the person affected will not be able to recollect the events after he will have been in the possession state. After this experience, the other people who witnessed the possession state will have to explain to the person who had been possessed as to exactly what happened.

T: What if you disregard ancestral instructions?

J: You will get sick. The ancestors will punish you for showing disrespect. If you decide to ignore the call and, say, go to Johannesburg to look for a job, the ancestors will make it difficult for you to find employment. They will haunt you until you come back home. Things will just generally go wrong in your life. In the case of a married woman, she will find herself unable to conceive. When such a person consults an indigenous healer to establish the reasons for the mishaps or problems, he will be informed about the disrespect that he will have shown to the ancestors.

APPENDIX B

INTERVIEW WITH MAGDALENE

- T: I am going to ask you a number of questions covering a wide range of topics related to your work as an indigenous healer. Firstly, I would like you to give me background information about yourself.
- M: My name is Magdalene Sebola. I have been practising as an indigenous healer for more than ten years now. Before I became an indigenous healer, I used to have a lot of strange dreams more frequently. I did not take these very seriously until when I got very ill. I was taken to the hospital with the hope that my condition would improve. This did not help and after some time my aunt suggested that I be taken to an indigenous healer. On consultation the indigenous healer pointed out that I have been called by my ancestors to become an indigenous healer. I was trained for almost a year before I was sent back home.
- T: I suppose there are various steps that should be followed in the process of indigenous healing. Would you like to tell me about this?
- M: The steps that one has to follow [when treating a patient] depend on the nature of the complaint that the patient is going to present with. It is thus very difficult to give a general explanation of the steps that should be followed if all the various illnesses are approached differently. Anyway, I will try my best to give you an overall picture. The first step that we generally take when a patient comes to consult is to throw the divination bones. These bones will give an indication to us as to the nature of the patient's problems. We do not expect the patient to tell us the nature of his problems. We can read all that from the fall of the bones.
- T: So your treatment programme is decided by what you read from the bones. Is that correct?
- M: Yes. We do not guess the diagnosis. We can always read the diagnosis from the bones. We have to ask the bones and they will give us the green light. Our intervention programmes will be decided by what the bones tell us.
- T: What kind of illness do you treat as an indigenous healer?
- M: I do not handle very complicated illnesses. My speciality is childhood ailments like "lekone" and headaches. I do also treat women who come to me with complaints about infertility. In the case of Western medicine, there is what is called kwashiorkor. We call

this kind of illness "metsho". A Western trained doctor will give his own kind of medicine. We have our own method of treatment for a child with such a problem. Usually the child with "metsho" will cry for no apparent reason. He will also appear startled and at times he will complain about seeing monkeys and other strange animals. Such a child will become very restless and have difficulties in falling asleep. He will also be afraid of many other things that are otherwise harmless. When a child [with "metsho"] is brought to us we will always start by throwing the bones in order to establish the nature of the problem. We will then communicate our impressions to the parents and also advice them about an appropriate treatment plan. If they agree with our diagnostic suggestions, we will then prescribe the medicines that will help the child.

T: How will you assess the success of your treatment?

M: Well, the child will begin to have a sound sleep without all these imaginary perceptions of monkeys and other strange animals. In the case of headaches, the parent will usually come and present the problem on behalf of the child. Like in the case of "metsho" we will first throw the divination bones in order to establish the nature of the problem.

T: In the case of childhood headaches, what are the symptoms that you will identify?

M: The child will show a number of clinical features. The eyes will show a dull appearance. The child will vomit a lot and also have a running stomach. This happens to very young children who are less than five years old. Once we have established the nature of the problem and a treatment plan, we will look for the appropriate herbs that are to be used to alleviate the child's problems. We burn such herbs and give to the child to "orela" (inhale the smoke). The residue of the burnt herbs is going to be prepared into a "tshidi" (ground ash) that will be mixed with the child's feeds. The medication given will soon arrest to running stomach and the vomiting.

T: Are you always satisfied with the outcome of your intervention programmes?

M: In my experience that stretches for over ten years, all the children that I have treated did recover. The other condition that I have always been successful with is "mootlwa". If a patient suffering from "mootlwa" is taken to the hospital, the Western doctor will perform a surgical operation to remove the diseased organ. We do not operate on the person.

T: What is "mootlwa"?

M: A person with this condition will complain of chronic stomach problems and excessive coughing. Such a patient will never get better if given the hospital medicines as these will only alleviate the symptoms for a short time. The problem will come back after a while because the doctors will have failed to treat the root causes. When a "mootlwa" patient comes to us the divination bones will indicate to us the nature of the problem. To locate its exact position inside the body we will make use of a live chicken which the patient will be advised to bring. The chicken is going to be rubbed with some herbs and moved all over the patient's body. The patient will be instructed to "huetsa" (breathe into) the chicken before it is slaughtered. By breathing into the chicken the disease is transferred from the patient to the chicken. Once slaughtered, the chicken is immediately cut open to enable us to locate the exact location of the disease. The diseased organ so identified is removed from the chicken and roasted on hot ashes. Some of the "tshidi" (burnt ashes) are then going to be added to the roasted portions. This preparation will then be suspended on needles and administered orally to the patient. The remaining portion of the chicken that is not diseased is going to be cooked and enjoyed as a meal. A portion of the "tshidi" will then be added to the soup derived from this cooked chicken and orally given to the patient. The remaining "tshidi" is given to the patient to take home and mix with his soft porridge. After a while, I usually receive very positive reports from such patients who will tell me that they have recovered. I also get a lot of reports from women who will have previously failed to conceive because of the "mootlwa". Some women will fail to conceive because they have a lot of "diso" (rash) inside their wombs. I have treated a lot of such women with success. Recently I did help such a lady who is teacher at the local primary school. Unfortunately for reasons best known to her she does not pay me.

T: You talked about the use of needles in the administration of medicines. Is there any particular reason for this?

M: I can not tell precisely why [we use needles to administer the medicines]. I learnt the skill to treat "mootlwa" from another indigenous healer in this village after I had problems with my own son who used to cough excessively a few years ago.

T: What is this "mootlwa" like?

M: "Mootlwa" develops on the intestines of the chicken. It is very difficult to describe this condition to you. As soon as we kill the chicken, we will see the needle-like growth attached to the intestines of the chicken. The problem with Western medicine is its tendency to cut everything. For such a problem as I have just described to you, a Western doctor will be tempted to cut open the patient in order to remove the ailment that will have been lodged inside the body. After some time the problem will surface again. Our method of treatment destroys the problem once and for all. We remove the disease so that a patient does not have to complain about the same problem again.

T: So you perform your operation on a chicken and not on people.

M: Yes. We do not operate on people's bodies. Our method is very safe because we use the chicken to establish the exact location of the illness in the patient's body. We then remove the diseased organ from the chicken and use it to treat the patient's illness. In other words, we use disease to treat disease.

T: Can you tell me more about this "go huetsa" activity?

M: As the chicken is run all over his body, the patient will be requested to breathe into the chicken. In so doing, the illness that is inside the patient is transferred to the chicken through the breath. It is just like in the case of "ditaola" (divination bones). Before a diagnostic session can begin, the patient will be requested to breathe into the divination bones. In so doing the patient's illness is transferred onto the bones. These two methods are more or less the same in the sense that they help us to arrive at a diagnosis of the problem. There is no way the "mootlwa" will fail to be revealed in the chicken if proper procedures have been followed. For those whose "mootlwa" illness was at an advanced stage, we can also discern from the bad state of the visceral organs of the chicken.

T: How do you assess the outcome of your treatment?

M: Usually the patient will come back to say that they feel much better. Such good reports by the patients also give us the confidence and good feelings that we are doing a good job in the community. However, if the patient comes back to say that the condition has not improved, you will be expected to prepare some more medicines. In this case there is no need to use another chicken. All that need to be done is to prepare the medicines and give to the patient. As I am explaining these procedures to you I am just thinking of a boy that

I treated a few years ago. He was brought to me with a long history of chronic stomach problems, loss of weight, and excessive coughing. He even had to drop out of school because his condition was interfering with his studies. At first I gave him some of our cough mixtures that I had prepared. This helped only for a while. After a few months the boy was brought to me again with the same problem. When I threw the bones I could see that he was suffering from "mootlwa". I then decided to request his parents to bring a live chicken that would be used to establish the exact location of the illness. Indeed the problem was located and treated. After a year or so the boy's parents came back with good news. I was informed that the boy's condition had so much improved that he had even gone back to school.

APPENDIX C

INTERVIEW WITH PAMOSA

T: How did you become an indigenous healer?

P: Before I started practising as an indigenous healer, I became seriously ill and spent twelve months in bed. During that time I could not eat or talk to anybody. My illness was so serious that even my relatives thought I was going to die. All the medicines that were given to me could not help. One day I had a dream that ultimately changed my life. In my sleep, I saw my grandfather approaching me with a wooden plate in his right hand. He was accompanied by another old man who I did not know. This other man had a very big knife in his hand. The two men just stood beside me without saying a word. After a while this other man started wielding the knife as if he was going to stab me. I got so scared that I screamed at the top of my voice. When my parents came into my bedroom, they found me seated on my sleeping mat. For the first time after a very long time I started talking. Everybody at home was surprised. From that day onwards I started having a lot of dreams in which my grandfather would show me different types of divination bones and medicines that I was supposed to use as an indigenous healer. This went on until I became proficient in the use of the divination bones and medicines. I was never trained by anyone. My ancestors guided me all the way until I became an indigenous healer.

T: Tell me about your practice as an indigenous healer.

P: In our practice we first have to establish the nature of a patient's problem through the divination bones. Once the diagnosis has been made, we will move to the next step of establishing the appropriate form of intervention. This treatment programme is arrived at also through the divination bones. The bones tell us exactly what kind of treatment will help the patient. We do not just use the medicines haphazardly. We always have to make sure that we have been guided by the bones. Just to give you an example. If you come to us complaining of painful legs and joints, we do not guess the type of treatment that should be appropriate for your condition. The first thing we have to do is to establish the nature of your problem through the divination bones. The treatment that will be given to you will depend on the nature of your problem as revealed by the divination bones. Even if the medicine that should be given requires mixing seven or eight herbs, we have to do

just that to make sure that you get better. The various herbs that will have been collected are then chopped into small pieces. These pieces are going to be burnt on a "leeta" (broken piece of clay pot). Whilst the herbs are burning, we will place the "leeta" next to your head and pull a blanket over your head so that you can inhale the smoke. At the end of this process, that is when we are satisfied that you have "orela" (inhaled), we will grind the burnt herbs into a "tshidi" (ground ash). We will "hlabela" (make small incisions) on your joints. These incisions should be deep enough to cause bleeding. As soon as the blood begins to show, we dip the "tshidi" in fat derived from a pig and rub this mixture into the incisions.

T: Any specific reason for using pig fat?

P: Pig fat has a neutralizing effect if your condition has been inflicted by witches. It has the capacity to stop evil forces if used properly. You may have heard about Makhwatla, a man who used to move around in this area a few years ago. This fellow used to attract a lot of attention around because of the magical activities that he performed. What was however interesting was that he did not allow anyone who had applied pig fat on his body to be in the audience during his magical performances. The fat would neutralize his magic.

T: So you find pig fat to be quite useful.

P: Yes. Usually when your illness is caused by witches, we mix the herbs with "tshidi" called "maloimaleko". This concoction is going to be left overnight in a bowl full of water. The following morning we will sprinkle this preparation all over your body. After some time you will certainly get better.

T: How do you know if what you are giving to a patient is the right treatment?

P: We are always guided by our ancestors in the practice. Without guidance by the ancestors, an indigenous healer will be like a wandering stranger whose path will lead into a cul de sac. Such a "ngaka" will not know the right treatment for his patients. We have a popular saying in North Sotho which goes like: "Malome a tsela ke molomo" [A wondering stranger's best companion is his mouth]. What I am saying here resembles what is expected of us as indigenous healers. We first have to throw the divination bones to establish the nature of our patient's condition. We do not rely on the opinions of others for appropriate treatment. Often such opinions will contradict the kind of treatment that will

be indicated by the divination bones.

T: Hmm, I see.

P: Unfortunately some indigenous healers tend to bypass this essential step of divination [throwing of the bones]. This is very dangerous as they will usually arrive at a wrong treatment. The best way always is to rely on the divination bones. At times a patient may complain of a headache and consult a Western medical doctor. Usually such a patient will be given a Panado or a Compral to relieve the headache. The problem with this type of treatment is that it is symptomatic as it only relieves the headache temporarily. Our solution to headaches is meant to be permanent. Let me explain to you how we treat a person with headaches. When such a patient consults, we use "letlobo" (snake skin). This is going to be ground and mixed with other types of herbs which are chopped and placed in a "leeta". This concoction is then placed next to the patient to "orela". The residue derived from these burnt herbs is ground into "tshidi" which is applied onto a thin rope that is going to be tied around the patient's head. After a few days the patient will be instructed to go to the bush and untie the rope from his head. This is then tied onto a tree. After doing that the patient has to come back without looking back. The patient will get better because his illness has been transferred to the tree in the bush. This is a permanent cure.

T: Is that so? What actually makes the patient to feel better?

P: The patient will get better because of the intervention of ancestors or God. In some cases it depends on your expectations as a patient. If you trust me, you will believe that my medicines are going to make you feel better. In other words, if you come to me with high hopes the chances are good that you will recover. At the end of the treatment when you feel much better you will praise me for being a good indigenous healer. The fact that you got better when you were in my care will convince you of my credentials as a good indigenous healer.

T: So the patient may likely come back to you in the future.

P: Yes. Remember, we always have to establish the exact nature of the patient's problem through the divination bones. This also applies to the nature of a treatment programme that has to be followed. In on the first throw the bones do not give us a good diagnostic

picture we always have to keep on trying. An indigenous healer who follows these guidelines properly will never go wrong. His patients will always recover after only a short period of time. This will equally apply in the case of those patients who are expected to stay with us to receive treatment. With proper treatment, we will cut down the length of time that such patients will spend with us. After a few days they will usually tell us that they are feeling much better and that they are ready to go back home. Another important thing about our inpatients is that we give them enough time to rest while at the same time they receive regular doses of medication.

T: Why do you give the patients enough rest and regular medication?

P: It is wrong to give a patient a lot of work to do. After all, he is going to pay you for your services. Why should you overwork him? The ancestors will not be pleased with you having to ill-treat your patients. As soon as we are convinced that the patient is much better, we will invite the relatives of the patient to come and make their own assessment. They will talk to him and communicate their impressions to me. If they are satisfied, they will pay me for the services. I do not take their money if I fail to cure the patient. If the patient gets better whilst he is in my care, he will always come back whenever he gets sick. If such a patient comes back within a year after discharge, he will not have to pay for the divination session. I will expect the payment only for the treatment that I will give. On the other hand if such a patient comes to me a year after I will have treated him for an illness, I will expect payment for both the divination session and the medicines. Another important thing to note here is that we do not use a patient's money immediately it is given to us as payment. Those who get tempted and use the money immediately will anger the ancestors. As soon as I am paid I need to inform the ancestors about this payment and thank them for the referral. If I fail to thank them [for the patient's payment] they will be so angered that they may decide to block the practice and bar any patients from coming to me. In other words, I will have closed the gate and thus stopped the flow of patients.

T: Hmm.

P: If a woman comes to us complaining about infertility, there is only one effective type of treatment. We mix some herbs and give these to the patient to "orela". The "tshidi"

derived from these burnt herbs is going to be given to her to take home. She will be advised to take this "tshidi" with her soft porridge every morning. After a fairly short time, the patient will usually come back to us smiling to say that she is expectant.

T: Hmm.

P: Sometimes we see children who suffer from "bolwetsi bja ditshwene" (monkey disease). Such a child will tend to be shy and very withdrawn to maintain eye contact. These symptoms will show that the child is having "bolwetsi bja ditshwene". We will prepare some herbs and give to the child to "orela". Usually it will take only a day or two for such a child to recover. Some children may present with what we call "metsho". Such children will tend to be fidgety and self destructive. Other symptoms related to "metsho" are a high temperature and intermittent crying spells. Children with this problem respond favourably to oral medication and treatment that is given through "go orela". Usually such a child will only take two to three days to recover if given proper treatment.

T: When it comes to childhood illnesses, how do you evaluate the effectiveness of your treatment programme?

P: We will usually notice some improvement from the way the child will start to behave after treatment. If a child has been suffering from "metsho", for example, we will see such a child becoming more contained and not running around. The child will participate meaningfully in play activities. Often the parents will come to us and say that the child is much better.

T: How do you relate to your patients?

P: Our patients are very important to us because they have been sent by our ancestors. We have to always treat them very well. If they are staying with us we will treat them like our family members. This means that if for some reason the patient misbehaves while staying with us, we will discipline them in much the same as we would to a family member. If the patient continues to misbehave, we will certainly start suspecting his mental condition.

T: How do you determine the dose that you give to your patients? Are there times when you accidentally give an overdose?

P: No. We always have to give the right dose. Even when the patient takes medication home, we will give instructions on appropriate quantities that need to be taken. It is obviously

dangerous to take an overdose as this will tend to complicate the patient's condition. Taking an overdose is like consuming more alcohol than your body can take. To get reasonably intoxicated, you only need to take enough alcohol that your system will be capable to handle. A similar situation obtains in the case of medication that we give to our patients.

T: It is often alleged that your doses are harmful because you do not have proper measurements. Is this true?

P: Yes. It may happen in the n the case where an indigenous healer does not follow proper instructions. If proper doses are given as guided by the divination bones, there is no way such a situation will arise. One important advice we always give to our patients is to avoid alcohol when they are on our medication. Mixing medicine and alcohol can be dangerous. I would like to tell you about one disease that I have always found fascinating to treat. This is called "vaal siek" or "bolwetsi bja go wa" (seizures). There are many treatment methods for this kind of disease. After establishing the nature of the problem through the use of the divination bones, we will advice the patient to bring along a goat. We use the goat to establish the exact area in the body where the disease is located. We run the goat over the patient's body and request him to breathe into its mouth. The goat will then be killed and cut open to see what is going on in its viscera. The cause of "vaal siek" is excessive blood in the patient's system thus leading to congested vessels. Once this happens, the patient collapses.

T: How do you identify this kind of disease?

P: The excessive blood will be clearly visible inside the goat. This congested blood chokes the veins and lead to intermittent seizures. It is a very dangerous disease because if the patient is alone at the time of the seizure, he may die. In order to treat our patient we will remove the diseased organ in the goat and mix this with some herbs that will have been chopped into small pieces. This concoction will be given to the patient to "orela" (inhale). The "tshidi" (ground ash) derived from these burnt herbs is applied to the patient's body through "go hlabela" (incision). The remaining "tshidi" is given to the patient to take home. This will have to be taken regularly with soft porridge. The patient [with "vaal siek"] will be advised to avoid salt in his food for a period of six to twelve months.

- T: Why do you impose such a long time of abstinence?
- P: This will give the patient's body enough time to heal. If there is a lot of salt in the patient's body, his illness will take too long to heal. It is also very important to advise the patient to avoid red meat. If these instructions are not followed, it will be extremely difficult for the patient to improve. If on the other hand these instructions are followed, the patient will improve quickly. Once we are convinced that the seizures are gone, the patient will be allowed to take salty food and red meat again.
- T: You have frequently made mention of the divination bones. Can you tell me more about these?
- P: The divination bones are derived from different types of animals. We have in our collection bones of lions, monkeys, wild bucks etc. We also have in our collection various types of shells that are obtained from the sea. During training, the budding indigenous healer will be visited by the ancestors who will indicate the type of bones and shells that need to be assembled to complete a set of divination bones. There are many ways in which the bones are interpreted. Sometimes we may say the bones are "asleep" if they do not give us an indication of the problem even after repeated attempts to throw them. At times the bones are said to be "awake" because they indicate to us the nature of the problem and treatment programme without having to try many times. All these different "moods" of the divination bones are dictated by the ancestors. Usually the bones that are "asleep" are a reflection of ancestral displeasure. The ancestors guide us all the way. They are like that careful passenger who will hasten to advise a driver who is leading a car into a ditch. If the driver does not heed the advice, a caring passenger will try to control the brakes and steering wheel to avoid an accident. The ancestors are also acting like a caring passenger. If after repeated warnings one does not listen, the ancestors will block his practice and no patients will come any longer.
- T: So the ancestors are always with you.
- P: Certainly. The ancestors are very powerful. They derive their power from God. If their orders are disobeyed, they get angry and decide to punish the offending individual by making him sick. When such a person comes to us for help, the divination bones will indicate to us that the ancestors have been angered and that certain rituals need to be

performed in order to re-establish the link between one's family and the spiritual world. The ancestors will further require such an individual to wear a specially made wrist or neck band which serves as a protective device. Just to give you an example here. There is a lady who recently came here because she had panic attacks and repeated episodes of sleeplessness. The divination bones indicated that the ancestors are angry with her family for having failed to observe certain rituals. Her treatment was two fold. Firstly, some herbs were given to her to take orally. Secondly, her family was required to perform certain rituals during which an ox was slaughtered and sacrificed to the ancestors. After she had taken all her medications and all the rituals had been performed, her relatives came to thank me for the improvement that was noticed.

T: Often people mention "malopo" as one of those aspects of indigenous healing. Would you like to tell me more about this?

P: "Malopo" is some form of possession by the spirits of one's forefathers. The spirits will expect those possessed to perform the "malopo" dance. "Malopo" will show in the form of an illness which will require appropriate treatment programme that includes the performance of "malopo" dance.

T: Does it mean that all people possessed by "malopo" end up being indigenous healers?

P: No. There are those who may pick up "malopo" illness because there is history of this experience in their families. If on the other hand one's possession is an indication of a call to become an indigenous healer, such an individual will be expected to go through the training programme that will involve acquisition of diagnostic and treatment skills.

T: Does a possessed person feel any pain?

P: Yes. During the possessed state, the person will cry and his body will shake uncontrollably. Crying is an indication that one feels pain. During the possessed state, one will not know what is going on around him. It is as if such a person is dreaming. It is only after regaining full senses that he will be told about everything that took place during the possessed state. It is like in the case of "ditlajane" which is caused by witches who have the ability to transport a person, whilst asleep, to a secret rendezvous in a far away place. Such a victim will be physically abused whilst transported. The witches will only return their victim early in the morning before sunrise. On waking up, such an abused person

will complain of general body pains. In such cases [of ditlajane] we will prescribe medicines that will need to be taken through "go orela". A portion of this medication will be given as a nasal inhalant. This is intended to open the victim's mind to recollect all that will have taken place during the night in question. Another important thing to do [for a "ditlajane" patient] will be to visit the victim's family in order to "aga motse" (protect the homestead). What has happened here is that the witches have turned the victim's home into their playground. Unless the homestead is strengthened, these evil people will keep on coming.

T: Is this "go aga motse" somehow related to the wrist and neck bands that you have earlier talked about?

P: There is some kind of connection between ["go aga motse" and the neck bands] because they all have a protective function. These protective devices make it difficult for the patient to be attacked by witches or any other kind of evil force. In the case of neck and wrist bands, the patient must always have these on his body.

T: Are there different types of indigenous healers?

P: Yes. We have ordinary "dingaka" (indigenous healers) and "dingaka tsa malopo" ("malopo" indigenous healers). These are two different categories. In the case of the latter, one will be possessed by "malopo" and will be expected to go through the "malopo" dance. One important thing here is that an ordinary "ngaka" would not be qualified to train a "ngaka ya malopo".

T: Would you like to talk about any other illnesses that you are able to treat?

P: Yes. At times I see women who complain of excessive menstruation. There are medicines that we use to treat this condition. At times men will come to me complaining about failure to ejaculate. There are appropriate medicines for such a condition. Another condition that is often dangerous is known as "mafofonyane". A person with this illness will behave like a mad person. He will run around aimlessly and undress in public. He will also cry for no apparent reason. This illness is brought about by witches. When a patient [with "mafofonyane"] is brought to us, we will start by establishing the exact nature of the problem through the divination bones. Once this has been done, we will throw the bones again to establish the treatment programme that will be appropriate for

that patient. Usually we will give the patient some medicines to "orela". Some of the medicines will be applied through "go hlabela" which serves a protective function. As soon as the patient improves, we will arrange with the patient's family to have him taken home. It is important to have the patient's home protected before he is taken back. If this is not done the patient will relapse. So we need to be sure that the patient's home environment is safe and well protected before he is taken back.

APPENDIX D

INTERVIEW WITH RAMMALO

T: When did you start practising as an indigenous healer?

R: In fact I started training as an indigenous healer in 1965. I was still very young at that time. Before I became an indigenous healer I fell ill. My family tried all forms of treatment without success. I was taken to several Western doctors but these could not help. At last I was initiated into the "malopo" dance. This proved to be the best treatment for my problems. My ancestors responded and made their intentions known. They did indicate that I should become an indigenous healer. I was trained by my brother who was also an indigenous healer. He taught me all the skills like divination and how to use the various herbs. He took me through all the stages of "go thwasa" (training) before I ultimately graduated as an indigenous healer.

T: Does it mean one has to be ill before he can train as an indigenous healer?

R: Yes. To train as an indigenous healer one has to be ill first and also one has to go through the "malopo" experience. There are others who will not go through this process. These are people who come from families which have indigenous healers. Such individuals will be taught the skills of indigenous healing by their relatives. Because they have not gone through the usual channels of ancestral guidance we call them "dingaka tshupsa" (those who have been guided by others). The difference between "ngaka" and "ngaka tshupsa" lies in the fact that the latter will only treat a limited number of conditions unlike a "ngaka" who will usually have a broad client base. Unlike a "ngaka tshupsa", a "ngaka" will be visited at night and guided by ancestors on matters like where to get herbs to treat patients. The ancestors will give an indication of how these herbs need to be mixed and what quantities have to be administered. These instructions need to be followed strictly.

T: So your treatment programmes are sanctioned by the ancestors.

R: Yes. As indigenous healers, we always have to rely on the ancestors because they are the ones to give us constant guidance. An indigenous healer who follows these guidelines as given by the ancestors will always be successful.

T: Let us go back for a while to your illness before you became an indigenous healer. How long did the illness take?

- R: For six months I was bed-ridden and all Western medicines could not help me. This was however a relatively short time as compared to many other indigenous healers who may be ill for many years. As soon as I completed my training, my brother started delegating some duties to me. At times he would, at the behest of patients, be away from home for a very long period of time. During these days of his absence, I would run his practice. When he came back home, he would be impressed with my work. Often I would give him a lot of money that I would have collected from the patients. So we worked in a partnership for many years. My brother was a senior partner. I only started practising on my own since 1980.
- T: You have been running your own practice for about 15 years now. What kind of patients have you been seeing all these years?
- R: I see all sorts of clients including the mentally disturbed, the epileptics, the unemployed who want medicines to help them secure jobs, people with sexually transmitted diseases, those who are in search of good fortunes and those who want their homesteads strengthened. The list is endless. If I strengthen your homestead, you will no longer fear witches, lightning, and all sorts of problems.
- T: From the description that you have just given, it sounds like you cover more scope than Western doctors. What is your comment?
- R: Yes. Our work covers a lot of areas compared to a Western doctor who will only work in the hospital.
- T: Could you tell me about the steps that your patient has to go through before you would be satisfied that he has recovered?
- R: When a patient comes here, the first thing he would like to know is the diagnosis. After we will have exchanged greetings, I will invite the patient together with his relatives into "ntlo ya badimo" (ancestral house or consulting room). I will throw the divination bones which will give me a complete picture of the patient's problems including those of the other family members. I will communicate all these impressions to the family members attending the divination session. If they concur with my diagnostic impressions, I will require them to give me an advance payment of R50 which is known as "phuthulla moraba". This will give me an indication of whether or not these people are serious. The

outstanding balance will only be settled once the patient has improved. The settlement amount asked will depend on the nature of the patient's problems.

T: What will give you an indication that the patient has improved?

R: It is always easy for us to tell if a patient has improved. If a patient comes here unable to walk, I will say he has improved only when I see him walking unaided. I have a patient at the moment who came almost two months ago. When she arrived here her condition was very bad. She was very weak as she had not been eating for a very long time. Right now she is much better. I can even arrange for you to see her. I am about to call her relatives to come and assess her condition. If they are satisfied, she will be discharged.

T: I will surely want to see her later. For now, I still want to get more information about your treatment methods.

R: You see if the relatives come and tell me that they are satisfied with the progress that the patient will have made, I tell them to arrange to welcome the patient back home. I will expect them to pay me only if they are satisfied with my services.

T: In your opinion what is it that cures your patients?

R: The medicines that we give to the patients make them better. All the medicines that we give to the patients have to be mixed with what we call "tshidi ya badimo". This "tshidi" (ground ash) must always be added regardless of whether the medicines are taken orally, through a steam bath or otherwise.

T: What is this "tshidi ya badimo"?

R: This is a very important component of our medical preparations. Every patient receiving my medication must have his medicines mixed with this "tshidi". Even if the patient is epileptic or mentally disturbed, this "tshidi" is very important. Without it there is no way a patient will get better.

T: How long does it take for an average patient to get better?

R: It depends on the nature of the illness, it may take a week, two weeks, or longer. If, for example, a patient is brought here in a critical condition and unable to walk, it will usually take longer. I will normally prescribe a course of treatment that will comprise of different types of medicine and rituals. Usually after two weeks we will begin to notice progress. The patient will also normally indicate to us that he feels much better.

- T: How about the patient's expectations? Do you think this has an influence?
- R: To some extent yes. What is more important is for his ancestors to wish to see him recovering. In other words, if his ancestors are not satisfied, the patient will not improve. Both my ancestors and the patient's ancestors must share a wish to see him improving. My interventions will not be effective if the patient's ancestors are not happy. There will have to be some kind of dialogue between my ancestors and those of the patient and this will facilitate recovery on the part of the patient.
- T: So the ancestors are very important.
- R: Yes. As soon as a patient arrives here we have to communicate with the ancestors. We throw the bones in order to discover the nature of the problem. Once the problem has been identified, we ask for a "phuthulla moraba" (initial fee). This is a fee that is paid by the patient before we can start with a treatment programme. It also gives us an indication of whether or not the patient and his relatives will be committed to the treatment programme which at times may take longer than they think. As soon as the "phuthulla moraba" fee is paid, I will perform a small ritual through which I request my ancestors to help me make the patient feel better. This is a very crucial step because it is ultimately the ancestors who bring about improvement on the part of the patient. In other words, there is no way you can successfully treat a patient without first communicating with the ancestors.
- T: What are your areas of specialization as an indigenous healer?
- R: I see a wide range of patients. I do however deal mainly with those patients who are mentally disturbed. I also see a lot of people who suffer from seizures. There are many others who come to see me because they want more luck. Still there are those who want to have their homesteads protected because they may complain about strange sounds that haunt them in their sleep. A lot of the clients I see in Johannesburg are usually those who want to have their homesteads protected. That is why I have been to all corners of this country because I have to go to my clients' homes in order to perform these protective rituals. After I will have protected their homestead, these people often come to thank me for the job well done. Usually people who want to have their homesteads protected against evil forces will complain of lack of sleep, fear, and that their children cry at night.

The medicines that I prepare help to chase away all these evil forces lurking in their homesteads.

T: What kind of medical preparations do you use to strengthen the homesteads?

R: We use a variety of herbs. Of course we have to add "tshidi ya badimo" to all these preparations. The other ingredients include barks, leaves, and roots of tall trees, bits of soil from the mountains, sand and water from the sea. All these ingredients are mixed and spiced with goat blood. This mixture is going to be sprayed all over the homestead.

T: Why specifically tall trees and extracts from the sea?

R: If you look at the tall trees you see them always blowing to the wind. As they blow fresh air is distributed all over. The extracts from these tall trees are going to help drive away all the evil forces and bring healthy conditions in the homestead.

T: You talked about sea water and sand. Why not use ordinary river sand and tap water?

R: No. We can not use ordinary sand or water. I am sure you have seen how strong a sea is. Everything that falls into the sea gets carried to far away places. By adding sea water to the ingredients, we are trying to clear the homestead of all the impurities that have been brought by the evil forces. Should we fail to secure sea water we can also use water obtained from the waterfalls. Sea water is always our first preference.

T: You also mentioned that you use the blood of a goat in your medicines. Why?

R: It all depends on the nature of the problem. If the problem is not so serious, we may use a fowl instead. This will of course depend on what the divination bones tell us. If we find that the people in the homestead are also having "senyama" (bad luck), we will also prescribe some medicines that are going to be used to cleanse their bodies.

T: What is "senyama"?

R: There are two or three types of "senyama". A man may get "senyama" through sexual contact with a woman who has aborted or is menstruating. Such a woman is seen to be polluted. Any sexual contact with her will bring "senyama". Such a woman is also dangerous if she comes into contact with children. Another type of "senyama" is caused by witchcraft. Some people with evil intentions may invoke "senyama" to strike a young man who is going to Johannesburg to look for a job. Even after repeated attempts to secure a job such a young man will not succeed. The witches are responsible for his

misfortunes. It is only after we will have "hlapisa" (cleansed) him with the appropriate medicines that he will be in a position to get a job. The third source of "senyama" has to do with our funeral customs. If you attend a funeral you will realize that there is always a basin at the entrance to the deceased's home. On our return from the cemetery we have to wash our hands in the basin so as to remove the "senyama" that is associated with the corpse and places like a cemetery. If this ritual is not observed you risk contaminating your family, particularly the children. You have to always wash your hands before you go back to your place. In some Christian families there is a tendency to spray all the people entering the deceased's home with holy water. At times this does not work. Still talking about funeral customs, if you eat food prepared at the funeral without washing your hands first, your stomach will swell. This will indicate to us that you have "senyama". For me as an indigenous healer it is even more important to wash my hands before I leave the deceased's home. Failure to do so will be disastrous as this will contaminate my consulting rooms, the divination bones, and the medicines. This will lead to a situation where patients will stop coming. I will have blocked my practice by being reckless.

T: Do you mean that one can carry the "senyama" to his place?

R: Yes. You need to make sure that your hands are washed.

T: I often hear that indigenous healers have "malopo". Would you like to explain to me how this relates to you?

R: In the case of "malopo" one is troubled by people who have passed away, that is, grandparents and great grandparents. By beating the drums during the "malopo" sessions we are inviting the ancestors to come closer. Apart from the drumming, we may also invite the ancestors by administering some medicines to the possessed. With repeated drumming, hand clapping, and song, the possessed will start shaking and crying. At this stage we will know that the ancestors have come closer. We will ask the ancestors to communicate their needs and intentions to us through the possessed person. They will tell us as to what should be done. They will also indicate to us the type of treatment that should be given to the possessed. If the ancestors indicate to us that they would like to have a goat or sheep as a sacrifice, we have to make sure that such an animal is made available. Failure to do so will only complicate the problems. If however we satisfy the

ancestors by doing everything they want, the person who is possessed will get better.

T: Why should the person shake at the time when he is possessed?

R: This shaking is caused by the ancestral spirits. They have come to settle in the person's body. In other words the person is no longer in his full senses. It is the ancestors who have taken over his body. All the utterances will come from the ancestors even if it will be the possessed person who expresses them. It is only when the ancestors leave the body that a person so possessed will regain full senses. During the "malopo" experience it is like the body is magnetized or frozen. The person will not recollect what happened during the possessed state. It is only when we give a full explanation of the events that he will know what happened. All the instructions that will have been given by the ancestors during the "malopo" episode will be followed. Sometimes it may happen that the possession has got nothing to do with one ultimately becoming an indigenous healer. It may be that the ancestors only want this person to perform the "malopo" dance. Once this has been done, the person will feel better. If on the other hand the "malopo" person is chosen to become an indigenous healer, we have to do much more than just the "malopo" dance. After a diagnosis [of "malopo" condition] will have been made, there will be a series of steps that will be followed. Because the individual concerned will also present with various complaints, these have to be treated. Whilst giving treatment to the patient, we will also start training him to become an indigenous healer. In this regard we will introduce him to all the divination procedures and medical knowledge. Apart from these [treatment] programmes that will be in place, the patient's ancestors will also be communicating with him regularly. They will come when he is asleep to show him where to find some medicines and how these need to be prepared. They will also indicate to the "thwasa" person (trainee healer) what kinds of paraphernalia he should have. Some animal skins and other types of paraphernalia may have to be obtained. Once all the steps have been followed, arrangements will be made to take the trainee back home.

T: I see.

R: The trainee's relatives will organize a big party that will take place on a Friday up to a Sunday when we will leave the trainee at his place. This will mean that he is ready to start practising as an indigenous healer.

- T: Does it mean that you always have to take your trainees back home on completion of their apprenticeship?
- R: Yes. We do that because the graduate's ancestors have to be taken back to where they belong. If we do not take the graduate back home, his ancestors will remain at my place and this will not be good for the practice of the new indigenous healer. We make arrangements with his family to organize food and drinks for the big take home ceremony which will be attended by the family and members of the community. It really becomes a big occasion because we will start celebrating on a Friday up to a Sunday when we will come back. For the entire weekend of the celebration, the graduate indigenous healer will be busy as many people will consult him with their problems. He has to prove to them that he is a good indigenous healer. If these people are satisfied, they will continue consulting him after we will have left his place.
- T: Are there other activities of significance during this take home ceremony?
- R: Yes. Usually on the Saturday of the ceremony, we will deliberately hide something and instruct the newly qualified indigenous healer to sniff out its whereabouts. His search will begin in full view of all the people attending the ceremony. If he discovers the whereabouts of the hidden item, we will be convinced that he is going to be a good indigenous healer. Even the people attending the function will be impressed and will thus want to bring their problems to him.
- T: Is the discovery of the hidden object not an accidental occurrence?
- R: No. Not at all. The new graduate will be guided by the ancestors to discover where the hidden object is. This will convince us further that the graduate is indeed guided by the ancestors.
- T: It is often suggested that indigenous healers are also witches. What is your comment on this?
- R: This is not the case. My ancestors guided me only to become an indigenous healer. They have not taught me to [be a witch and to] harm others. In fact ancestors can not teach you to harm others. They guide us to help others. All those who have evil intentions are not guided by ancestors. It is their own evil intentions. A witch is born in a family of witches.
- T: Are you saying that a "ngaka" is only there to help other people?

- R: Precisely. A "ngaka" is selected by the ancestors to be of service to the community. Ancestors will thus not tolerate to guide a person who will also have evil intentions to harm others. You are either a "ngaka" or a witch. Our mission as "dingaka" is as good as that of the Western medical doctor who helps people.
- T: What will happen to someone who ignores a call to become an indigenous healer?
- R: Such a person will never have a peace of mind. The ancestors will haunt him all the way. Even if he may decide to go as far as Johannesburg to dodge the call, the ancestors will follow him there. They will keep haunting him until he is forced to come back home to heed their call. If he continues to ignore this call, the ancestors will make him sick or bring a lot of misfortune to his family.
- T: Coming to the divination bones. Is it possible for you to treat a person without first having to throw the divination bones?
- R: It is possible even though this is not common. Treating a patient without first throwing the bones to discover the nature of his problem is like walking with your eyes closed. It will be difficult to know whether or not your interventions are appropriate.
- T: Would it be possible for anyone to learn to divine through the bones without ancestral guidance?
- R: It may be possible [for a person to learn to divine through the bones without ancestral guidance] to some extent. Such a person will however not be successful because he is not guided by the ancestors. After a while you may find that this person has forgotten everything he has learnt because all the knowledge will not be a gift from the ancestors. On the other hand, someone who is guided by the ancestors will never experience problems like the ones I have mentioned. In fact his diagnostic skills and knowledge of the divination bones will be broadened. The ancestors will usually visit at night to advise him on how he should practice as an indigenous healer. They will even show him where the herbs can be obtained. We have a category of "dingaka" which is called "dingaka tshupsa". These are people who are born in a family of indigenous healers. Often you will find a practising indigenous healer confiding in a niece, nephew or one of his children. As time goes on, the skills will be passed to this young person who will go on to practice when the indigenous healer dies or is no longer able to carry on with his duties. The scope

of a "ngaka tshupsa" is limited as compared to that of a "ngaka" who has been called by the ancestors. For example, a "ngaka tshupsa" will treat the fairly straight forward ailments like head and stomach aches. A "ngaka" on the other hand will handle a wide range of conditions, including those that are brought about by witches and ancestors.

T: What actually happens during the divination session?

R: You should realize that indigenous healers do not work like the doctors in the hospital. If a patient goes to the hospital, he has to tell the doctor what the problem is. The doctor will then give treatment on the basis of the information that is given by the patient. We do not do that. All we expect the patient to do is to only indicate on arrival that he has come to consult. The patient will be instructed to breathe into the bones and to throw them on the mat. As an indigenous healer I will read the patient's problems from the bones. After I will have established the nature of the problem, the patient will be instructed to breathe into the bones again. This second throw of the bones is intended to establish the appropriate treatment programme that will have to be prescribed for the patient.

T: So your approach is very different from that of a Western doctor?

R: Yes. We do not expect the patient to tell us what the problem is. It is our duty to tell the patient what the problem is. The patient is free to disagree with our findings and to even claim his money back in case he is not satisfied with our diagnosis or suggested treatment programme. Usually our patients will be satisfied with our divination sessions and treatment programme. There are many occasions when patients would come back and thank me heartily for the work that I will have done.

T: How do you treat the mentally disturbed?

R: I will normally follow the same procedures like in the case of other illnesses except that I will have to give the patient medicines that are specifically intended to treat mental illness. A mentally ill person will usually be brought by the relatives who will complain that he is aggressive, hearing voices, laughing inappropriately or running around. After I will have established the nature of the problem, I will advice the relatives to leave the patient with me so that I can monitor his progress closely. The medicines that I will give to the patient will drive out all these voices and tame the patient. I will usually give the medication in the form of a steam bath. As soon as I am beginning to see improvement on

the part of the patient, I will invite his relatives to come and make their own observations of the patient. This will usually be after three or four weeks. If they are satisfied, I will arrange to have the patient discharged. The most important thing to do before the patient gets home is for me to go and strengthen his homestead. If this is not done, the patient will soon come back because the evil forces that are lurking in the homestead will still be there. I have to go and drive out all these evil forces that have caused the illness. All family members will also have to be protected so that they do not become mentally ill. Once the patient is sent back home, I will advise the relatives to bring the patient back every year so that I can make follow up treatment.

T: So you always have to treat the patient and the family.

R: Yes. Since the illness started in the family, it is important for us to make sure that everyone in the family is healthy. The other thing is that if the witches realize that the patient has improved, they may want to come back and strike another member of the family. It is therefore important to protect all the other members against potential illness.

T: How will you know that a mentally disturbed patient has improved?

R: Usually the patient will, after a few weeks of treatment, tell me that he is feeling much better. This will in a way also give me an indication that his senses are coming back. The other method of testing whether or not there is improvement is to send the patient to the shops to buy a few items. A patient who has improved will oblige and buy the items as instructed. If the patient is still sick, he will fail to follow the instructions as directed.

T: Are there cases that you sometimes fail to treat?

R: Yes. One or two cases will at times be difficult to treat. If I realize that the patient does not improve, I will first communicate with my ancestors asking them to show me the best treatment programme. If I fail even after such an attempt, I will consult my colleagues and ask for their opinions. If I fail even with their advice, I will then refer the patient to another indigenous healer.

APPENDIX E
NORTHERN PROVINCE TRADITIONAL DOCTORS ASSOCIATION
CONSTITUTION

1. PREAMBLE:

We the traditional doctors of the Northern Province whose names and other particulars are subscribed to this constitution;

- (a). Having found one another by the characteristics of our natural profession being traditional doctoring and healing,
- (b). Being unhappy with reference to us as witch-doctors, preferring rather to be referred to as traditional-doctors (T/Drs.)
- (c). Admitting that witchcraft do exist and forcing us to deal in antidotes to neutralize its effect,
- (d). Realizing that the calling of people's names as witches or wizard is a violation of the principle of divination,
- (e). Realising the freedom we are now in after the political overturn of apartheid government led by the National Party,
- (f). Heeding the call of the new government to participate in the integrated health delivery system, hereby voluntarily come out to the open and form a provincial association of all traditional doctors, healers, herbalists and spirit mediums.

2. NAME:

The name of the Association shall be the Northern Province Traditional Doctors Association. Its praise-name(sereto) shall be "Kgolomodumo".

3. AIMS AND OBJECTIVES

- (a). To unite all traditional doctors, healers, herbalists, spirit medium, surgeons and midwives.
- (b). To promote traditional medicine and practice.
- (c). To promote research into traditional medicine and method of healing in consultation with membership.
- (d). To supervise the practice of traditional medicine, prevent abuse and quackery.
- (e). To co-operate with the ministry of health, other ministries and organisations that

are involved in the field of health.

- (f). To preserve and promote beneficial aspects of African culture.
- (g). To co-operate with the traditional health profession in other countries.

4. MEMBERSHIP

- (a). Membership is open to all traditional-doctors who have undergone traditional healing initiation school (thwasa) of repute, spirit mediums, herbalists and faith healers.
- (b). No person with criminal record for the past five years shall be admitted as a member.
- (c). Joining fee fixed by Provincial Executive Committee from time to time shall be payable on enrolling each member.
- (d). Each member shall be supplied with membership card and certificate.
- (e). Each member shall be registered with the established statutory council of T.M.P's.
- (f). Membership shall be lost through: Resignation, Death, and Expulsion.
- (g). On resignation, death or expulsion no refund will be made of:
 - (i). Joining fee
 - (ii). Subscription fee.

5. THE PROVINCIAL EXECUTIVE COMMITTEE.

- (a). The provincial executive committee shall consist of the following office bearers
 - (i). President
 - (ii). Vice-President
 - (iii). Secretary
 - (iv). Vice-Secretary
 - (v). Treasurer
 - (vi). Publicity Secretary
 - (vii). Secretary for culture
 - (viii). Secretary for legal affairs
 - (ix). Secretary for education and research
- (b). The president shall be the chairperson of the provincial executive committee.
- (c). The office-bearers mentioned in section 5(a) (i - ix) shall be elected by the

delegates at the congress of the association.

- (d). Members of the Provincial Executive Committee shall be elected every five years.
- (e). The provincial executive committee shall have powers to establish executive posts as may be necessary from time to time.

6. MEETINGS

- (a). The provincial executive committee shall hold meeting at such times and at such places as the Executive Committee shall deem convenient.
- (b). One-third of the members of provincial executive committee shall form a quorum.
- (c). All decisions of the P.E.C shall be on a simple majority vote of those present at a properly constituted meeting.
- (d). Disciplinary powers of the Association shall be exercised by the Provincial Executive Committee.
- (e). The Provincial Executive Committee may appoint a manager and such other employees as it considers to be necessary or desirable.

7. DUTIES OF OFFICE-BEARERS

- (a). President
 - (i). He/she shall be the head of the Association.
 - (ii). He/she shall ensure discipline and order in the Association.
 - (iii). He/she shall ensure adherence to the Associations' policy by all officials and members and is empowered hereby to suspend from office any person, who act or speaks contrary to the rules and regulation of the Association.
- (b). Vice-President
 - (i). He/she shall assist the President in his /her duties and assume responsibilities of the President in the latter's absence.
- (c). Secretary
 - (i). He/she shall run the Association under the direction of the President.
- (d). Vice-Secretary
 - (i). He/she shall assist the secretary in his/her duties and assume the responsibility in the absence of the secretary.

- (e). Treasurer
 - (i). He/she shall be in charge of the association's financial affairs under the direction of the president.
- (f). Publicity Secretary
 - (i). He/she shall be responsible for promoting the image of the association through media.
 - (ii). He/she shall be the spokesperson to the media under the direction of the president.
- (g). Secretary for culture
 - (i). He/she shall be in charge of cultural affairs under the direction of the president.
- (h). Secretary for legal affairs
 - (i). He/she shall be the chairperson of the disciplinary committee.
- (i). Secretary for education and research
 - (i). He/she shall be in charge of educational and research programmes under the direction of the president.

8. **FINANCE**

- (a). The funds of the Association shall consist of all fees paid in terms of regulation referred to in section 4, donations and other moneys and assets as may vest in or accrue to the association.
- (b). All moneys shall be deposited in a bank approved by the Provincial Executive Committee.
- (c). The account of the association shall be audited annually,
- (d). Signatories to association's banking account shall be the president, secretary and treasurer.
- (e). A member of the association shall be paid from the funds of the association such allowance as the Provincial Executive Committee may fix to meet any reasonable expenses incurred by him/her in connection with the business of the administration.

9. REGIONS AND BRANCHES

- (a). The association shall establish regions and branches throughout the province with executive committee consisting of:
 - (i) Chairperson
 - (ii) Vice-chairperson
 - (iii) Treasurer
 - (iv) Organiser
 - (vii) Security-welfare secretary
 - (viii) Cultural officer
 - (ix) Two additional members
- (b). Each branch shall consist of 20 members at least.
- (c). Each region shall consist of 4 branches.
- (d). Branch and regional executive committees shall be elected every five years.

10. CONGRESS

- (a). The congress shall be held every five years at a place and date decided by the Provincial Executive Committee.
- (b). The congress shall be composed of delegates as follows:
 - (i). All members of Provincial Executive Committee
 - (ii). All members of the Traditional Medical Practitioners' Council.
 - (iii). All members of Regional Executive Committee.
 - (iv). All chairpersons of branch executive committee.

11. DISCIPLINE

Disciplinary offences shall include:

- (i). Fraud or misappropriation of funds
- (ii). Failure to abide by the constitution
- (iii). Performing any act pertaining to traditional healing profession in a grossly incompetent manner.
- (iv). Improper conduct, or disgraceful conduct or conduct which, when regard is had to the profession or calling of that person, is improper or disgraceful.

- (v). The sale of medicine in open spaces such as road sides and unauthorised market places.
- (vi). The sale of medicine by unqualified persons.
- (vii). Any other offence listed by the Traditional Medical Practitioners Council.

12. AMENDMENT TO THE CONSTITUTION

Amendment to the constitution shall be by 2/3(two-third) majority of those members present at the congress.

13. DISSOLUTION

The association may, by a resolution passed by 2/3 (two-third) majority of members at a special conference called expressly for that purpose, for that purpose, resolve that the association be dissolved. All properties and funds of the association , after meeting all liabilities shall be distributed in such a manner as shall be determined by the conference.

